Public Employees Benefits Board

Certificate of Coverage

Group Health Options, Inc. | HealthPays® HSA (CDHP) Plan for Active Employees

2012

Published under the direction of the Washington State Health Care Authority

GroupHealth
Well beyond medicine®

GROUP HEALTH OPTIONS, INC.

HSA PLAN

FOR ACTIVE PEBB EMPLOYEES

FOR BENEFITS AVAILABLE BEGINNING JANUARY 1, 2012

Certificate of Coverage

Group Health Options, Inc. (also referred to as "GHO") is a Health Care Service Contractor, duly registered under the laws of the State of Washington, furnishing health care coverage on a prepaid basis.

Please Read And Save This Document
You Are Responsible For Understanding Your Benefits

This book is your Certificate of Coverage with GHO, and explains benefits specific to your health plan. This Certificate of Coverage supersedes all previous certificates. If there are inconsistencies with federal or state statute or rules, the statute or rule will have precedence. The Consumer-Directed Health Plan (CDHP) Agreement is a Health Savings Account (HSA) Health Plan. The health plan meets all of the requirements to be used in conjunction with a Member-initiated Health Savings Account. The provisions of the Agreement do not override, or take the place of, any regulatory requirements for Health Savings Accounts. Participation in a health savings account is not a requirement for enrollment or continued eligibility on the Agreement.

GHO is not a trustee, administrator or fiduciary of any Health Savings Account which may be used in conjunction with the Agreement. Please contact the Health Savings Account trustee or administrator regarding questions about requirements for Health Savings Accounts.

A full description of benefits, exclusions, limits and Out-of-Pocket Expenses can be found in the Benefit Details, Page 15; Benefit Exclusions and Limitations, Page 35; and Allowances Schedule, Page 10. These sections must be considered together to fully understand the benefits available under the Agreement. Words with special meaning are capitalized. They are defined in Terms Used in this Booklet, Page 4.

Note: Various Cost Shares may or may not be eligible for determining the Member’s annual Health Savings Account contribution limit. Please contact the Health Savings Account trustee or administrator regarding questions about requirements for Health Savings Accounts.

Important Phone Numbers

Consulting Nurse:	1-800-297-6877
Customer Service	1-888-901-4636
TTY WA Relay	1-800-833-6388
Emergency Notification Line:	1-888-457-9516

Visit Our Web Site for PEBB Employees at www.ghc.org/pebb

CONTENTS

Terms Used in This Booklet

Agreement: The PEBB benefit plan.

Allowance: The maximum amount payable by GHO for certain Covered Services under the Agreement, as set forth in the Allowances Schedule.

Allowed Charge: Allowed charge means one of the following:

> Contracting Providers: The allowed charge is the amount agreed upon between GHO and the provider for Medically Necessary Covered Services.
>
> Providers who have contracts with GHO agree not to bill Enrollees for any charges above the amount agreed upon by GHO and the provider, except for any Deductibles, Coinsurance, Copayments, amounts in excess of stated benefit maximums and charges for noncovered services for which the Enrollee is responsible.
>
> Non-Contracting Providers: The Usual, Customary and Reasonable (UCR) charges made by providers for Medically Necessary services covered under this Agreement.
>
> Except for emergency care inside the Service Area or Emergency or urgent care outside the Service Area, services received from non GHO Providers without a authorization by GHO are not covered.

Annual Deductible. The annual Deductible amount a Member must pay is determined by whether the Member is a sole Subscriber or has enrolled Dependents.

Subscriber Only Coverage (individual coverage). Charges subject to the annual Deductible shall be borne by the Subscriber during each calendar year until the annual Deductible is met.

Family Coverage (coverage for the Subscriber plus one (1) or more Dependents). Charges subject to the annual Deductible shall be borne by the Subscriber during each calendar year until the total family annual Deductible is met. The total family annual Deductible can be met by one member or by all family members in combination. Until the total family annual Deductible is met, benefits will not be provided for any family member under the Agreement.

a. MHCN. Covered Services received from a MHCN Provider are subject to the annual Deductible, as set forth in the Allowances Schedule.

   Covered Services must be obtained at MHCN Facilities in order to be applied to the annual Deductible, unless the Member has received **an Authorization in advance** or has received Emergency services according to the Schedule of Benefits, Section IV.L.

b. Community Provider. Covered Services received from a Community Provider are subject to the annual Deductible as set forth in the Allowances Schedule.

Authorization: An approval by GHO that entitles an Enrollee to receive Covered Services from a specified health care provider at the MHCN benefit level. Services shall not exceed the limits of the Authorization and are subject to all terms and conditions of the Agreement. Enrollees who have a complex or serious medical or psychiatric condition may receive a standing Authorization for specialist services.

Community Provider: Physicians licensed under 18.71 or 18.57 RCW, registered nurses licensed under 18.79 RCW, midwives licensed under 18.79 RCW, naturopaths licensed under 18.36A RCW, acupuncturists licensed under 18.06 RCW, podiatrists licensed under 18.22 RCW or, in the case of non-Washington State providers, those providers meeting equivalent licensing and certification requirements established in the state where the provider's practice is located. For purposes of the Agreement, Community Providers do not include individuals employed by or under contract with the MHCN or who provide a service or treat Members outside the scope of their licenses.

Contracted Network Pharmacy: A pharmacy that has contracted with GHO to provide covered legend (prescription) drugs and medicines for outpatient use under the Agreement.

Copayment: The specific dollar amount an Enrollee is required to pay at the time of service for certain Covered Services under the Agreement, as set forth in the Allowances Schedule.

Cost Share: The portion of the cost of Covered Services the Enrollee is liable for under the Agreement. Cost Shares for specific Covered Services are set forth in the Allowances Schedule. Cost Share includes Copayments, Coinsurances and/or Deductibles.

Covered Services: The services for which an Enrollee is entitled to coverage under the Agreement.

Custodial/Convalescent Care: Care that is designed primarily to assist the Enrollee in activities of daily living, including institutional care that serves primarily to support self-care and provide room and board. Custodial care includes, but is not limited to, help in walking, getting into and out of bed, bathing, dressing, feeding and preparing special diets, and supervision of medications that are ordinarily self-administered. GHO reserves the right to determine which services constitute custodial or convalescent care.

Deductible: A specific amount an Enrollee is required to pay for certain Covered Services before benefits are payable under the Agreement. The applicable Deductible amounts are set forth in the Allowances Schedule.

Emergency: The emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent lay person acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily function or serious dysfunction of a bodily organ or part, or would place the Enrollee’s health in serious jeopardy.

Enrollee: Any subscriber or dependent enrolled under the Agreement.

Essential Health Benefits: Benefits set forth under the Patient Protection and Affordable Care Act of 2010, including the categories of ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care.

Experimental or Investigational Services:

a) A service is considered experimental or investigational for an Enrollee's condition if any of the following statements apply to it at the time the service is or will be provided to the Enrollee. The service (i) cannot be legally marketed in the United States without the approval of the Food and Drug Administration ("FDA") and such approval has not been granted; or (ii) is the subject of a current new drug or new device application on file with the FDA; or (iii) is provided as part of a Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial, or in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the service; or (iv) is provided pursuant to a written protocol or other document that lists an evaluation of the service's safety, toxicity, or efficacy as among its objectives; or (v) is under continued scientific testing and research concerning the safety, toxicity, or efficacy of services; or (vi) is provided pursuant to informed consent documents that describe the service as experimental or investigational, or in other terms that indicate that the service is being evaluated for its safety, toxicity, or efficacy; or as to the service: (vii) the prevailing opinion among experts as expressed in the published authoritative medical or scientific literature is that (1) use of such service should be substantially confined to research settings, or (2) further research is necessary to determine the safety, toxicity, or efficacy of the service.

b) In making determinations whether a service is experimental or investigational, the following sources of information will be relied upon exclusively: (i) the Enrollee's medical records, (ii) the written protocol(s) or other document(s) pursuant to which the service has been or will be provided, (iii) any consent document(s) the Enrollee or Enrollee's representative has executed or will be asked to execute, to receive the service, (iv) the files and records of the Institutional Review Board (IRB) or similar body that approves or reviews research at the institution where the service has been or will be provided, and other information concerning the authority or actions of the IRB or similar body, (v) the published authoritative medical or scientific literature regarding the service, as applied to the Enrollee's illness or injury, and (vi) regulations, records, applications, and any other documents or actions issued by, filed with, or taken by, the FDA, or other agencies within the United States Department of Health and Human Services, or any state agency performing similar functions.

c) Appeals regarding denial of coverage can be submitted to the Member Appeals Department, or to GHO’s Medical Director at P.O. Box 34593, Seattle, WA 98124-1593. GHO will respond in writing within twenty (20) working days of the receipt of a

fully documented appeal request. An expedited appeal is available if a delay would jeopardize the Enrollee's life or health.

Family Planning Services: Those medical care services related to planning the birth of children through the use of birth control methods, including elective sterilization.

Fee Schedule: A fee-for-service schedule adopted by the MHCN, setting forth the fees for MHCN medical and hospital services.

Health Savings Account (HSA): A tax-exempt savings account established exclusively for the purpose of paying qualified medical expenses and meeting other requirements under federal law.

Hospital Care: Those Medically Necessary services generally provided by acute general hospitals for admitted patients. Hospital Care does not include convalescent or custodial care, which can, in the opinion of the provider, be provided by a nursing home or convalescent care center.

Managed Health Care Network (MHCN): The participating provider with which GHO has entered into a written participating provider agreement for the provision of Covered Services. GHO's participating provider is Group Health Cooperative.

Medical Condition: A disease, illness or injury.

Medically Necessary: Appropriate and clinically necessary services, if recommended by the Enrollee's treating provider and by GHO's Medical Director, or his/her designee, according to generally accepted principles of good medical practice, which are rendered to an Enrollee for the diagnosis, care or treatment of a Medical Condition and which meet the standards set forth below. In order to be Medically Necessary, services and supplies must meet the following requirements: (a) are not solely for the convenience of the Enrollee, his/her family or the provider of the services or supplies; (b) are the most appropriate level of service or supply which can be safely provided to the Enrollee; (c) are for the diagnosis or treatment of an actual or existing Medical Condition unless being provided under GHO's schedule for preventive services; (d) are not for recreational, life-enhancing, relaxation or palliative therapy, except for treatment of terminal conditions; (e) are appropriate and consistent with the diagnosis and which, in accordance with accepted medical standards in the State of Washington, could not have been omitted without adversely affecting the Enrollee's condition or the quality of health services rendered; (f) as to inpatient care, could not have been provided in a provider's office, the outpatient department of a hospital or a non-residential facility without affecting the Enrollee's condition or quality of health services rendered; (g) are not primarily for research and data accumulation; and (h) are not Experimental or Investigational Services. The length and type of the treatment program and the frequency and modality of visits covered shall be determined by GHO's Medical Director, or his/her designee. In addition to being medically necessary, to be covered, services and supplies must be otherwise included as a covered service as described in the "Benefit Details" section of this booklet and not excluded from coverage. The cost of non-covered services and supplies shall be the responsibility of the Enrollee.

Medicare: The federal health insurance program for the aged and disabled.

MHCN-Designated Specialist: A GHO specialist specifically identified by GHO.

MHCN Facility: A facility (hospital, medical center or health care center) owned, operated or otherwise designated by the MHCN.

MHCN Personal Physician: A provider who is employed by or contracted with the MHCN to provide primary care services to Members and is selected by each Member to provide or arrange for the provision of all non-emergent Covered Services, except for services set forth in the Agreement which a Member can access without an Authorization. Personal Physicians must be capable of and licensed to provide the majority of primary health care services required by each Member.

MHCN Provider: The medical staff, clinic associate staff and allied health professionals employed by the MHCN and any other health care professional or provider with whom the MHCN has contracted to provide health care services to Members enrolled under the Agreement, including, but not limited to, physicians, podiatrists, nurses, physician assistants, social workers, optometrists, psychologists, physical therapists and other professionals engaged in the delivery of healthcare services who are licensed or certified to practice in accordance with Title 18 Revised Code of Washington.

Out-of-Pocket Expenses: Those Cost Shares paid by the subscriber or Enrollee for Covered Services, which are applied to the Out-of-Pocket Limit.

Out-of-Pocket Limit (Stop Loss): The maximum amount of Out-of-Pocket Expenses incurred and paid, during the calendar year for Covered Services received by the subscriber and his/her dependents within the same calendar year. The Out-of-Pocket Limit amount and Cost Shares that apply are set forth in the Allowances Schedule. Charges in excess of UCR, services in excess of any benefit level and services not covered by the Agreement are not applied to the Out-of-Pocket Limit.

Plan Coinsurance: The percentage amount the Enrollee and GHO are required to pay for Covered Services received under the Agreement. Percentages for Covered Services are set forth in the Allowances Schedule.

a. MHCN. After the annual Deductible is satisfied, Members shall be required to pay the Plan Coinsurance for Covered Services as set forth in the Allowances Schedule.

b. Community Provider. After the annual Deductible is satisfied, Members shall be required to pay the Plan Coinsurance for Covered Services as set forth in the Allowances Schedule.

   A benefit-specific coinsurance may apply to some Covered Services, as set forth in the Allowances Schedule. Services that are subject to the benefit-specific coinsurance are not subject to the Plan Coinsurance.

Preferred Community Provider: A Community Provider that has agreed to accept from GHO a contracted rate for Covered Services under Section IV. Services received from a Preferred Community Provider are subject to a discounted rate, less any Cost Shares set forth in the Allowances Schedule.

Preferred Community Provider Contracted Rate: The discounted rate that the Preferred Community Provider has agreed to accept from GHO for medical services received by Members.

Proof of Continuous Coverage: The Certificate of Creditable Coverage provided to the Enrollee by the Enrollee's prior health plan; or a letter from the Enrollee's employer, on the employer's letterhead, providing the time period the Enrollee and/or dependent(s) of the Enrollee were covered by health insurance.

Residential Treatment: A term used to define facility-based treatment, which includes twenty-four (24) hours per day, seven (7) days per week rehabilitation. Residential Treatment services are provided in a facility specifically licensed in the state where it practices as a residential treatment center. Residential treatment centers provide active treatment of patients in a controlled environment requiring at least weekly physician visits and offering treatment by a multi-disciplinary team of licensed professionals.

Service Area: Washington counties of Benton, Columbia, Franklin, Island, King, Kitsap, Kittitas, Lewis, Mason, Pierce, San Juan, Skagit, Snohomish, Spokane, Thurston, Walla Walla, Whatcom, Whitman and Yakima; Idaho counties of Kootenai and Latah; and any other areas designated by GHO.

Urgent Condition: The sudden, unexpected onset of a Medical Condition that is of sufficient severity to require medical treatment within twenty-four (24) hours of its onset.

Usual, Customary and Reasonable (UCR): Expenses are considered Usual, Customary and Reasonable if the charges are consistent with those normally charged to others by the provider or organization for the same services or supplies; and the charges are within the general range of charges made by other providers in the same geographical area for the same service or supplies. Amounts charged by a Community Provider in excess of UCR rates are the responsibility of the Subscriber and/or Member.

ALLOWANCES SCHEDULE

MHCN: Describes coverage when care is provided by a MHCN Provider. Benefits paid under the MHCN option will not be duplicated under the Community Provider option.

Community Provider: Describes coverage when care is provided by a Community Provider or Preferred Community Provider. Coverage is limited to the Preferred Community Provider Contracted Rate or Usual, Customary and Reasonable (UCR) charges, less any applicable Cost Share amounts as noted below. Benefits paid under the Community Provider option will not be duplicated under the MHCN option.

Benefits will be provided at the payment levels specified below and in the benefits section of this booklet up to the benefit maximum limits. The services below correspond with the benefit descriptions in the following section, "Benefit Details." Please read the "Benefit Details" and "What's Not Covered" sections for specific benefit limitations, maximums, and exclusions.

Payment Summary

.

Cost Shares	MHCN (In- Network) Benefits	Community Provider (Extended Network) Benefits
Annual Deductible	$1,400 **Individual** (In-network and Extended network is shared) $2,800 **Family** (In-network and Extended network is shared) All services are subject to this Annual Deductible unless otherwise noted. The Annual Deductible amount an enrollee must pay is determined by whether the enrollee is a sole Contract Holder or has enrolled Dependents	
Annual Out-of-Pocket Limit	$5,100 **Individual** (In-network and Extended network is shared) $10,200 **Family** (In-network and Extended network is shared) The Annual Out-of Pocket Limit is determined by whether the enrollee is a sole Contract Holder or has enrolled Dependents.	
Plan Coinsurance	10%	30%

Covered Service	MHCN (In- Network) Benefits	Community Provider (Extended Network) Benefits

Covered Service	MHCN (In- Network) Benefits	Community Provider (Extended Network) Benefits
1. Accidental Injury to Teeth	Payment levels are determined by the service provided.	Payment levels are determined by the service provided.
2. Ambulance Services Air Ambulance Ground Ambulance	Annual Deductible and Plan Coinsurance applies.	Annual Deductible and Plan Coinsurance applies.
3. Ambulatory Surgical Center	Annual Deductible and Plan Coinsurance applies.	Annual Deductible and Plan Coinsurance applies.
4. Blood and Blood Derivatives	Annual Deductible and Plan Coinsurance applies.	Annual Deductible and Plan Coinsurance applies.
5. Chemical Dependency Services	Annual Deductible and Plan Coinsurance applies.	Annual Deductible and Plan Coinsurance applies.
6. Diabetic Education	Annual Deductible and Plan Coinsurance applies.	Annual Deductible and Plan Coinsurance applies.
7. Diagnostic Laboratory and Radiology Services	Annual Deductible and Plan Coinsurance applies.	Annual Deductible and Plan Coinsurance applies.
8. Durable Medical Equipment, Supplies and Prostheses	Annual Deductible and Plan Coinsurance applies.	Annual Deductible and Plan Coinsurance applies.
9. Emergency Room Services	Annual Deductible and Plan Coinsurance applies.	Annual Deductible and Plan Coinsurance applies.
10. Hearing Care Routine Exam Hearing Aids Enrollee pays any costs over the covered benefit of $800 every 36 months.	Annual Deductible and Plan Coinsurance applies.	Annual Deductible and Plan Coinsurance applies.
11. Home Health	Annual Deductible and Plan Coinsurance applies	Annual Deductible and Plan Coinsurance applies
12. Hospice Care **Respite Care:** up to 5 days maximum per 3 month period of hospice care	Annual Deductible and Plan Coinsurance applies Annual Deductible and Plan Coinsurance applies	Annual Deductible and Plan Coinsurance applies Annual Deductible and Plan Coinsurance applies
13. Hospital Services Inpatient Outpatient	Annual Deductible and Plan Coinsurance applies Annual Deductible and Plan Coinsurance applies	Annual Deductible and Plan Coinsurance applies Annual Deductible and Plan Coinsurance applies

Covered Service	MHCN (In- Network) Benefits	Community Provider (Extended Network) Benefits
14. Mental Health Care		
Inpatient	Annual Deductible and Plan Coinsurance applies	Annual Deductible and Plan Coinsurance applies
Outpatient	Annual Deductible and Plan Coinsurance applies	Annual Deductible and Plan Coinsurance applies .
15. Neurodevelopmental Therapy For Children Age 6 and Younger		
Inpatient - 60 days per year	Annual Deductible and Plan Coinsurance applies	Annual Deductible and Plan Coinsurance applies
Outpatient - 60 visits per year for all therapies combined	Annual Deductible and Plan Coinsurance applies	Annual Deductible and Plan Coinsurance applies
16. Obstetrical Care		
Inpatient	Annual Deductible and Plan Coinsurance applies	Annual Deductible and Plan Coinsurance applies
Outpatient	Annual Deductible and Plan Coinsurance applies	Annual Deductible and Plan Coinsurance applies

Covered Service	MHCN (In- Network) Benefits	Community Provider (Extended Network) Benefits
17. Office and Clinic Visits (Other than Preventive)	Annual Deductible and Plan Coinsurance applies	Annual Deductible and Plan Coinsurance applies
Acupuncture	For services provided by a GHC Provider up to a maximum of eight (8) visits per Member per medical diagnosis per calendar year. When approved by GHO, additional visits are covered subject to the office visit Copayment.	Up to a maximum of eight (8) visits per Member per medical diagnosis per calendar year. When approved by GHO, additional visits are covered subject to the office visit Copayment.
Naturopathy	Annual Deductible and Plan Coinsurance applies For services provided by a GHC Provider up to a maximum of three (3) visits per Member per medical diagnosis per calendar year. When approved by GHO, additional visits are covered subject to the office visit Copayment.	Annual Deductible and Plan Coinsurance applies Up to a maximum of three (3) visits per Member per medical diagnosis per calendar year. When approved by GHO, additional visits are covered subject to the office visit Copayment.
18. Organ Transplants		
Inpatient facility services	Annual Deductible and Plan Coinsurance applies	Annual Deductible and Plan Coinsurance applies
Inpatient professional services		
19. Phenylketonuria (PKU) Supplements	Annual Deductible and Plan Coinsurance applies	Annual Deductible and Plan Coinsurance applies
20. Physical, Occupational, Speech and Massage Therapies		
Inpatient - 60 days per year	Annual Deductible and Plan Coinsurance applies	Annual Deductible and Plan Coinsurance applies
Outpatient - 60 visits per year for all therapies combined	Annual Deductible and Plan Coinsurance applies	Annual Deductible and Plan Coinsurance applies

Covered Service	MHCN (In- Network) Benefits	Community Provider (Extended Network) Benefits
21. Prescription Drugs, Insulin and Diabetic Supplies Retail - Up to a 30 day supply	Annual Deductible applies:	Annual Deductible applies:
Value Based List Prescriptions	$5 Copayment per prescription or refill	$5 Copayment per prescription or refill
Generic drugs listed in the GHC drug formulary (Tier 1)	$20 Copayment per prescription or refill.	$20 Copayment per prescription or refill.
Brand name drugs listed in the GHC drug formulary (Tier 2)	$40 Copayment per prescription or refill.	$40 Copayment per prescription or refill.
Non-formulary generic and brand name drugs (Tier 3)	50% coinsurance up to a $250 limit per prescription or refill.	50% coinsurance up to a $250 limit per prescription or refill.
Mail-Order drugs and medicines dispensed through the GHC-designated mail order service - Up to 90-day supply	Annual Deductible applies:	
Value Based List Prescriptions	$10 Copayment per prescription or refill	Not available through the Extended Network.
Generic drugs listed in the GHC drug formulary (Tier 1)	$40 Copayment per prescription or refill.	
Brand name drugs listed in the GHC drug formulary (Tier 2)	$80 Copayment per prescription or refill.	
Non-formulary generic and brand name drugs (Tier 3)	50% coinsurance up to a $750 limit per prescription or refill.	
22. Preventive Care	100%	Annual Deductible and Plan Coinsurance applies
23. Radiation-Chemotherapy Services	Annual Deductible and Plan Coinsurance applies	Annual Deductible and Plan Coinsurance applies

Covered Service	MHCN (In- Network) Benefits	Community Provider (Extended Network) Benefits
24. Reconstructive Surgery	Annual Deductible and Plan Coinsurance applies	Annual Deductible and Plan Coinsurance applies
25. Skilled Nursing Facility; 150 days per year	Annual Deductible and Plan Coinsurance applies	Annual Deductible and Plan Coinsurance applies
26. Manipulations of the spine and other extremities	Annual Deductible and Plan Coinsurance applies	Annual Deductible and Plan Coinsurance applies
27. Temporomandibular Joint Dysfunction (TMJ) – Up to $1,000 per calendar year	Annual Deductible and 50% coinsurance applies	Annual Deductible and 50% coinsurance applies
28. Tobacco Cessation Services	Covered in full for counseling; covered in full when prescribed as part of the GHO-designated tobacco cessation program and dispensed through the GHO designated mail order service	Annual Deductible and Plan Coinsurance applies for counseling; covered at RX for approved pharmacy products
29. Vision Care (Routine) Routine Eye Exams: one exam each 12 months	Annual Deductible and Plan Coinsurance applies	Annual Deductible and Plan Coinsurance applies
30. Optical Hardware	Hardware is covered in full up to $150 each 24 months: either lenses and frames, or contact lenses	Hardware is covered in full up to $150 each 24 months: either lenses and frames, or contact lenses

Benefit Details

All benefits are subject to the exclusions, limitations, and eligibility provisions contained in this booklet. GHO provides services through all types of health care providers licensed under state law. Benefits are payable for preventive care and Medically Necessary Services that are provided by GHO Providers or obtained in accordance with authorization requirements, except for Emergency care or as provided under coordination of benefits provisions. Authorization requirements are described in the "Preauthorization Procedures" section of this booklet. Services received after termination of PEBB coverage, will not be covered. Except when required by law, the Enrollee will be liable for any services provided after termination of PEBB coverage.

1. ACCIDENTAL INJURY TO TEETH

The services of a licensed dentist will be covered subject to the Plan Coinsurance for repair of accidental injury to natural teeth, after the annual Deductible is satisfied. Evaluation of the injury and development of a written treatment plan must be completed within 30 days from the date of injury. Treatment must be completed within the time frame established in the treatment plan unless delay is medically indicated and the written treatment plan is modified. Services and supplies for the following are not covered: Injuries caused by biting or chewing; malocclusion resulting from an accidental injury; orthodontic treatment; dental implants; conditions not directly resulting from the accident; and treatment not completed within the time period established in the written treatment plan.

2. AMBULANCE SERVICES

Emergency ground ambulance services are subject to the Plan Coinsurance per trip to a GHO Facility, or the nearest facility where care is available, after the annual Deductible is satisfied. If ground ambulance services are not appropriate for transporting the Enrollee to the nearest facility, the plan covers emergency air ambulance subject to the Plan Coinsurance per trip, after the annual Deductible is satisfied. The service must meet the definition of an Emergency and be considered the only appropriate method of transportation, based solely on medical necessity.

Interfacility Transfers.

a. MHCN-Initiated Transfers. MHCN-initiated non-emergent transfers to or from a MHCN Facility are covered as set forth in the Allowances Schedule.
b. Community Provider-Initiated Transfers. When prescribed by the attending physician, transport from a medical facility to the nearest facility equipped to render further Medically Necessary treatment is covered as set forth in the Allowances Schedule.

3. AMBULATORY SURGICAL CENTER

Services at an ambulatory surgery center (discharged within 24 hours of admission) are covered subject to the Plan Coinsurance, after the annual Deductible is satisfied. Services must be provided at a GHO Facility.

General anesthesia services and related facility charges in conjunction with any dental procedure performed in an ambulatory surgical center are covered subject to the Plan Coinsurance after the annual Deductible is satisfied if such anesthesia services and related facility charges are Medically Necessary because the Enrollee:

1. Is under the age of seven, or physically or developmentally disabled, with a dental condition that cannot be safely and effectively treated in a dental office; or

2. Has a Medical Condition that the Enrollee's physician determines would place the Enrollee at undue risk if the dental procedure were performed in a dental office. The procedure must be approved by the Enrollee's physician.

Preauthorization by GHO is required for general anesthesia services and related facility charges.

For the purpose of this section, "general anesthesia services" means services to induce a state of unconsciousness accompanied by a loss of protective reflexes, including the ability to maintain an airway independently and respond purposefully to physical stimulation or verbal command. Nitrous oxide analgesia is not reimbursable as general anesthesia.

4. BLOOD AND BLOOD DERIVATIVES

Blood and blood derivatives, including, but not limited to, synthetic factors, plasma expanders, and their administration, are covered subject to the Plan Coinsurance when Medically Necessary, after the annual Deductible is satisfied.

5. CHEMICAL DEPENDENCY TREATMENT

Chemical dependency means an illness characterized by a physiological or psychological dependency, or both, on a controlled substance and/or alcoholic beverages, and where the user's health is substantially impaired or endangered or his/her social or economic function is substantially disrupted.

For the purposes of this section, the definition of Medically Necessary shall be expanded to include those services necessary to treat a chemical dependency condition that is having a clinically significant impact on an Enrollee’s emotional, social, medical and/or occupational functioning.

Chemical dependency treatment services are covered subject to the Plan Coinsurance, after the annual Deductible is satisfied (1) under the MHCN option when provided at a MHCN Facility or MHCN-approved treatment program, or (2) under the Community Provider option when provided at an approved treatment facility.

All alcoholism and/or drug abuse treatment services must be: (a) provided at a facility as described above; and (b) deemed Medically Necessary as defined above. Chemical dependency treatment may include the following services received on an inpatient or outpatient basis: inpatient Residential Treatment services, diagnostic evaluation and education, organized individual and group counseling and/or prescription drugs and medicines.

Court-ordered treatment shall be covered only if determined to be Medically Necessary as defined above.

Under the Community Provider option, non-Washington State alcoholism and/or drug abuse treatment service providers must meet the equivalent licensing and certification requirements established in the state where the provider's practice is located.

6. DIABETIC EDUCATION

Medically Necessary diabetic education is covered subject to the Plan Coinsurance for each visit, after the annual Deductible is satisfied. Services must be prescribed by a MHCN Provider and approved by GHO.

7. DIAGNOSTIC X-RAY, NUCLEAR MEDICINE, ULTRASOUND AND LABORATORY SERVICES

Laboratory or diagnostic imaging, including, but not limited to, x-rays, ultrasound, mammography, nuclear medicine and allergy testing, provided by a MHCN Provider are covered subject to the Plan Coinsurance, after the annual Deductible is satisfied. Screening and diagnostic procedures during pregnancy, and related genetic counseling when Medically Necessary for prenatal diagnosis of congenital disorders, are included.

8. DURABLE MEDICAL EQUIPMENT AND SUPPLIES (FOR HOME USE) AND PROSTHESES

The Agreement covers the rental or purchase of durable medical equipment and medical supplies (for home use) and prostheses subject to the Plan Coinsurance, after the annual Deductible is satisfied. Must be preauthorized by the Enrollee's Personal Physician and obtained through a MHCN Provider. Disposable supplies used for treatment of diabetes are covered under the "Prescription Drugs, Insulin, and Diabetic Supplies" benefit.

Durable medical equipment is defined as equipment which can withstand repeated use, is primarily and customarily used to serve a medical purpose, is useful only in the presence of an illness or injury and used in the Enrollee's home. Durable medical equipment includes: hospital beds, wheelchairs, walkers, crutches, canes, glucose monitors, external insulin pumps, oxygen and oxygen equipment. GHO, in its sole discretion, will determine if equipment is made available on a rental or purchase basis.

Orthopedic appliances, which are attached to an impaired body segment for the purpose of protecting the segment or assisting in restoration or improvement of its function.

Ostomy supplies for the removal of bodily secretions or waste through an artificial opening.

Prosthetic devices are items which replace all or part of an external body part, or function thereof.

Covered services include:

1. the rental or purchase (at the option of GHO) of durable medical equipment such as wheelchairs, hospital beds, and respiratory equipment (combined rental fees shall not exceed full purchase price);
2. diabetic equipment not covered in the pharmacy benefit;
3. casts, splints, crutches, trusses or braces;
4. oxygen and rental equipment for its administration;
5. ostomy supplies;
6. artificial limbs or eyes (to replace a missing portion of the eye);

7. the initial external prosthesis and bra (limited to two (2) every six (6) months) necessitated by reconstructive breast surgery following a mastectomy, and replacement of these items when necessitated by normal wear, a change in Medical Condition, or when additional surgery is performed that warrants a new prosthesis and/or bra;
8. penile prosthesis when impotence is caused by a covered Medical Condition (not psychological), is a complication which is a direct result of a covered surgery, or is a result of an injury to the genitalia or spinal cord, and other accepted treatment has been unsuccessful;
9. a wig or hairpiece to replace hair lost due to radiation therapy or chemotherapy for a covered condition, up to a lifetime maximum payment of $100 per person; and
10. breast pumps.

Excluded: take-home dressings and supplies following hospitalization; any other supplies, dressings, appliances, devices or services which are not specifically listed as covered above; and replacement or repair of appliances, devices and supplies due to loss, breakage from willful damage, neglect or wrongful use, or due to personal preference.

9. EMERGENCY/URGENT CARE

Emergency Care (See Terms Used in This Booklet for a definition of Emergency)

All services are covered subject to the Plan Coinsurance after the annual Deductible is satisfied.

A. At a MHCN Facility. GHO will cover Emergency care for all Covered Services.

Inpatient Emergency care received at a MHCN Facility is also subject to:

i. Notification of GHO by way of the GHO Notification Line within twenty-four (24) hours following inpatient admission, or as soon thereafter as medically possible;
ii. Transfer of care to a MHCN Provider; and
iii. Transfer to another MHCN Facility if transferability is medically possible as determined by the MHCN.

B. At a Non-MHCN Facility. Usual, Customary and Reasonable charges for Emergency care for Covered Services are covered subject to:

1. Payment of the Emergency care Cost Share; and
2. Notification of GHO by way of the GHO Notification Line within twenty-four (24) hours following inpatient admission, or as soon thereafter as medically possible.

C. Waiver of Emergency Care Cost Share.

1. Waiver for Multiple Injury Accident. If two or more Enrollees in the same family require Emergency care as a result of the same accident, coverage

for all Enrollees will be subject to only one (1) Emergency care Copayment.

2. Emergencies Resulting in an Inpatient Admission. If the Enrollee is admitted to a MHCN Facility directly from the emergency room, the Emergency care Copayment is waived. However, coverage will be subject to the inpatient services Copayment.

D. Transfer and Follow-up Care. If an Enrollee is hospitalized in a non-MHCN Facility, GHO reserves the right to require transfer of the Enrollee to a MHCN Facility, upon consultation between a MHCN Provider and the attending physician. If the Enrollee refuses to transfer to a MHCN Facility, all services received will be covered under the Community Provider option.

Under the MHCN option, follow-up care which is a direct result of the Emergency must be received from MHCN Providers, unless a MHCN Provider has authorized such follow-up care from a non-MHCN Provider in advance. Follow-up care for services received under the Community Provider option, that is a direct result of the Emergency, is covered subject to the Cost Shares set forth in the Allowances Schedule.

Urgent Care (See Terms Used in This Booklet for a definition of Urgent Condition)

Under the MHCN option, care for Urgent Conditions is covered at MHCN medical centers, MHCN urgent care clinics or MHCN Providers' offices, subject to the Plan Coinsurance, after the annual Deductible is satisfied. Urgent care received at any hospital emergency department is not covered unless authorized in advance by GHO.

Under the Community Provider option, charges for Urgent Conditions received at any medical facility are covered subject to the applicable Cost Share.

10. HEARING EXAMINATIONS AND HEARING AIDS

Hearing examinations to determine hearing loss are covered, subject to the Plan Coinsurance, after the annual Deductible is satisfied. Hearing aids and rental/repair, including fitting and follow-up care, are covered to a maximum plan payment of $800 every 36 months, when authorized by a MHCN Provider. Hearing aids are not subject to the annual Deductible.

11. HOME HEALTH

Home health care services, as set forth in this section, shall be covered (1) under the MHCN option, when authorized in advance and provided by MHCN's Home Health Services or by GHO, or (2) under the Community Provider option when provided by a State-licensed home health agency, prescribed by a Community Provider and authorized in advance by GHO's Medical Director, or his/her designee.

In order to be covered, the following criteria must be met:

A. The Enrollee is unable to leave home due to his/her health problem or illness. Unwillingness to travel and/or arrange for transportation does not constitute inability to leave the home.

B. The Enrollee requires intermittent skilled home health care services, as described below.

C. A MHCN Provider under the MHCN option, or GHO's Medical Director, or his/her designee, under the Community Provider option, has determined that such services are Medically Necessary and are most appropriately rendered in the Enrollee's home.

For the purposes of this section, "skilled home health care" means reasonable and necessary care for the treatment of an illness or injury which requires the skill of a nurse or therapist, based on the complexity of the service and the condition of the patient and which is performed directly by an appropriately licensed professional provider.

Covered Services for home health care may include the following when rendered pursuant to an approved home health care plan of treatment: nursing care, physical therapy, occupational therapy, respiratory therapy, restorative speech therapy, durable medical equipment and medical social worker and limited home health aide services. Home health services are covered on an intermittent basis in the Enrollee's home. "Intermittent" means care that is to be rendered because of a medically predictable recurring need for skilled home health care services.

Excluded: convalescent care, custodial care and maintenance care, private duty or continuous nursing care in the Enrollee's home, housekeeping or meal services, care in any nursing home or convalescent facility, any care provided by or for a member of the patient's family and any other services rendered in the home which do not meet the definition of skilled home health care above or are not specifically listed as covered under the Agreement.

12. HOSPICE CARE (INCLUDING RESPITE CARE)

Hospice care, as set forth in this section, shall be covered (1) under the MHCN option when provided by MHCN's Hospice Program or when authorized in advance by GHO, or (2) under the Community Provider option when provided by a licensed non-MHCN hospice agency. Hospice care is covered in lieu of curative treatment for terminal illness for Enrollees who meet all of the following criteria, subject to the Plan Coinsurance, after the annual Deductible is satisfied:

- A physician has determined that the Enrollee's illness is terminal and life expectancy is six (6) months or less.
- The Enrollee has chosen a palliative treatment focus (emphasizing comfort and supportive services rather than treatment aimed at curing the Enrollee's terminal illness).
- The Enrollee has elected in writing to receive hospice care through a hospice program.

- The Enrollee has available a primary care person who will be responsible for the Enrollee's home care.
- A physician and the hospice agency have determined that the Enrollee's illness can be appropriately managed in the home.

Hospice care shall mean a coordinated program of palliative and supportive care for dying Enrollees by an interdisciplinary team of professionals and volunteers centering primarily in the Enrollee's home.

A. Covered Services. Care may include the following as prescribed by a physician and rendered pursuant to an approved hospice plan of treatment, after the annual Deductible is satisfied:

    1. Home Services

        a. Intermittent care by a hospice interdisciplinary team that includes a physician, nurse, medical social worker, physical therapist, speech therapist, occupational therapist, respiratory therapist, limited services by a Home Health Aide under the supervision of a Registered Nurse and homemaker services.
        b. Continuous care services in the Enrollee's home when prescribed by a physician, as set forth in this paragraph. “Continuous care” means skilled nursing care provided in the home during a period of crisis in order to maintain the terminally ill Enrollee at home. Continuous care may be provided for pain or symptom management by a Registered Nurse, Licensed Practical Nurse or Home Health Aide under the supervision of a Registered Nurse. Continuous care is covered up to twenty-four (24) hours per day during periods of crisis. Continuous care is covered only when a physician determines that the Enrollee would otherwise require hospitalization in an acute care facility.

    2. Inpatient Hospice Services. For short-term care, inpatient hospice services shall be covered according to the provisions set forth under 13. Hospital Services.

        Respite care is covered at the Plan Coinsurance, after the annual Deductible is satisfied, in the most appropriate setting for a maximum of five (5) days per occurrence in order to continue care for the Enrollee in the temporary absence of the Enrollee’s primary care giver(s).

    3. Other covered hospice services may include the following:

        a. Drugs and biologicals that are used primarily for the relief of pain and symptom management.
        b. Medical appliances and supplies primarily for the relief of pain and symptom management.
        c. Durable medical equipment.
        d. Counseling services for the Enrollee and his/her primary care-giver(s).
        e. Bereavement counseling services for the family.

B. Hospice Exclusions. All services not specifically listed as covered in this section are excluded, including:

1. Financial or legal counseling services.
2. Meal services.
3. Custodial or maintenance care in the home or on an inpatient basis, except as provided above.
4. Services not specifically listed as covered by the Agreement.
5. Any services provided by members of the patient's family.
6. Convalescent care.

13. HOSPITAL SERVICES

Hospital Inpatient Services:

The following hospital services are covered, (1) under the MHCN option when provided or authorized by the MHCN, or (2) under the Community Provider option when authorized in advance by GHO:

This Agreement covers Medically Necessary hospital accommodation and inpatient services, supplies, equipment, and drugs prescribed by a MHCN Provider for treatment of covered conditions (including, but not limited to, general nursing care, surgery, diagnostic tests and exams, radiation and x-ray therapy, blood and blood derivatives, bone and eye bank services, and take-home medications dispensed by the hospital at the time of discharge). Inpatient hospital services are subject to the Plan Coinsurance, after the annual Deductible is satisfied. Convalescent, custodial or domiciliary care is not covered.

Covered services under this benefit include those provided by the MHCN Provider, specialist, surgeon, assistant surgeon (when deemed medically necessary) and anesthesiologist.

Except as specifically provided below, all inpatient admissions prescribed by a Community Provider must be authorized by GHO at least seventy-two (72) hours in advance.

Members receiving the following nonscheduled services are required to notify GHO by way of the GHO Notification Line within twenty-four (24) hours following a nonscheduled admission, or as soon thereafter as medically possible: labor and delivery, Emergency care services, and inpatient admissions needed for treatment of Urgent Conditions that cannot reasonably be delayed until prior authorization can be obtained.

Members may not transfer to a MHCN hospital during a nonemergent, scheduled admission to a non-MHCN hospital. Coverage for Emergency care in a non-MHCN Facility and subsequent transfer to a MHCN Facility is set forth in Section IV.L.

Excluded: take home drugs, dressings and supplies following hospitalization

Outpatient Hospital Services:

Services for outpatient surgery, day surgery, or short-stay obstetrical services (discharged within 24 hours of admission) are covered subject to the Plan Coinsurance, after the annual Deductible is satisfied.

Dental Anesthesia - Inpatient/Outpatient:

General anesthesia services and related facility charges in conjunction with any dental procedure performed in a hospital are covered, subject to the Plan Coinsurance, after the annual Deductible is satisfied, if such anesthesia services and related facility charges are Medically Necessary because the Enrollee:

1. Is under the age of seven, or physically or developmentally disabled, with a dental condition that cannot be safely and effectively treated in a dental office; or

2. Has a Medical Condition that the Enrollee's physician determines would place the Enrollee at undue risk if the dental procedure were performed in a dental office. The procedure must be approved by the Enrollee's physician.

Preauthorization by GHO is required for general anesthesia services and related facility charges in conjunction with any dental procedure. Dentist and oral surgeon fees are not covered.

For the purpose of this section, "general anesthesia services" means services to induce a state of unconsciousness accompanied by a loss of protective reflexes, including the ability to maintain an airway independently and respond purposefully to physical stimulation or verbal command. Nitrous oxide analgesia is not reimbursable as general anesthesia.

14. MENTAL HEALTH CARE

Mental health services are covered only when: (1) determined by GHO to be Medically Necessary, (2) preauthorized by GHO, and (3) provided by a GHO psychiatrist (M.D.), GHO psychologist (Ph.D.), community mental health agency licensed by the Department of Health, state hospital, or other GHO Provider.

Inpatient: Professional and facility services for diagnosis and treatment of mental illness are covered subject to the Plan Coinsurance and GHO's preauthorization requirements, after the annual Deductible is satisfied. This includes medically necessary diagnosis and treatment of eating disorders (bulimia and anorexia nervosa).

Under the Community Provider option, inpatient mental health services are limited to the services rendered by a physician (licensed under RCW 18.71 and RCW 18.57); a psychologist (licensed under RCW 18.83); a community mental health agency licensed by the Washington State Department of Social and Health Services (pursuant to RCW 71.24); a master’s level therapist (licensed under RCW 18. 225.090), an advanced practice psychiatric nurse (licensed under RCW 18.79) or, in the case of non-Washington State providers, those providers meeting equivalent licensing and certification requirements established in the state where the provider's practice is located.

Outpatient: Services for diagnosis and treatment of mental illness are covered subject to the Plan Coinsurance and the requirements to obtain prior authorization, after the annual Deductible is satisfied. This includes Medically Necessary diagnosis and treatment of eating disorders (bulimia and anorexia nervosa). Visits for the sole purpose of medication management are covered as Medical Conditions.

Under the Community Provider option, outpatient mental health services are limited to the services rendered by a physician (licensed under RCW 18.71 and RCW 18.57); a psychologist (licensed under RCW 18.83); a community mental health agency licensed by the Washington State Department of Social and Health Services (pursuant to RCW 71.24); a master's level therapist (licensed under RCW 18. 225.090), an advanced practice psychiatric nurse (licensed under RCW 18.79) or, in the case of non-Washington State providers, those providers meeting equivalent licensing and certification requirements established in the state where the provider's practice is located.

Preauthorization is not required for emergency admissions, including involuntary commitment to a state hospital. This Agreement will cover court-ordered treatment only if determined by GHO to be Medically Necessary. All costs for mental health care in excess of the coverage provided under this Agreement, including the cost of any care for which the Enrollee failed to obtain prior authorization, will be the Enrollee's sole responsibility to pay.

15. NEURODEVELOPMENTAL THERAPY FOR CHILDREN AGE 6 AND YOUNGER

Physical therapy, occupational therapy and speech therapy services for the restoration and improvement of function for neurodevelopmentally disabled children age six (6) and under shall be covered, after the annual Deductible is satisfied. Coverage includes maintenance of a covered Enrollee in cases where significant deterioration in the Enrollee's condition would result without the services. Coverage for inpatient services is limited to 60 days per calendar year subject the Plan Coinsurance, after the annual Deductible is satisfied. Coverage for outpatient services is limited to 60 visits per calendar year subject to the Plan Coinsurance, after the annual Deductible is satisfied, as set forth in the Allowances Schedule.

Excluded: specialty treatment programs such as cardiac rehabilitation; inpatient Residential Treatment services; specialty rehabilitation programs, including "behavior modification programs"; long-term rehabilitation programs; physical therapy, occupational therapy and speech therapy services when such services are available (whether application is made or not) through programs offered by public school districts; recreational, life-enhancing, relaxation or palliative therapy; implementation of home maintenance programs; programs for treatment of learning problems; any services not specifically included as covered in this section; and any services that are excluded under Benefit Exclusions and Limitations.

16. OBSTETRIC AND NEWBORN CARE

Inpatient maternity care, including care for complications of pregnancy and prenatal and postpartum visits are covered subject to the Plan Coinsurance after the annual Deductible is satisfied. Outpatient Maternity care, including care for complications of pregnancy and prenatal and postpartum visits are covered subject to the Plan Coinsurance, after the annual Deductible is satisfied.

Prenatal testing for the detection of congenital and heritable disorders when Medically Necessary as determined by GHO's Medical Director, or his/her designee, and in accordance with Board of Health standards for screening and diagnostic tests during pregnancy.

Hospitalization and delivery, including home births for low risk pregnancies. Planned home births must be authorized in advance by GHO.

Services related to voluntary and involuntary termination of pregnancy on an outpatient basis are covered, subject to the Plan Coinsurance after the annual Deductible is satisfied. Inpatient services related to voluntary and involuntary termination of pregnancy are covered, subject to the Plan Coinsurance after the annual Deductible is satisfied.

The Enrollee's physician, in consultation with the Enrollee, will determine the Enrollee's length of inpatient stay following delivery. Pregnancy will not be excluded as a Pre-Existing Condition under the Agreement. Treatment for post-partum depression or psychosis is covered only under the mental health benefit.

Excluded: birthing tubs, genetic testing of non-Enrollees for the detection of congenital and heritable disorders, fetal ultrasound in the absence of medical indications.

17. OFFICE AND CLINIC VISITS

Outpatient services are covered subject to the Plan Coinsurance, after the annual Deductible is satisfied.

Family planning services are covered when provided by a MHCN Provider or women's health care provider. Prescription contraceptive supplies and devices (such as, but not limited to, IUDs, diaphragms, cervical caps and long-acting progestational agents) determined most appropriate by a MHCN Provider or women's health care provider for use by the Enrollee are also covered. Elective sterilization is covered.

Covered acupuncture and naturopathy as set forth in the Allowances Schedule after the annual Deductible is satisfied. Additional visits are covered when approved by GHO.

Excluded: herbal supplements, preventive care visits for acupuncture and any services not within the scope of the practitioner's licensure.

18. ORGAN TRANSPLANTS

Transplant services including heart, heart-lung, single lung, double lung, kidney, pancreas, cornea, intestinal/multi-visceral, bone marrow, liver transplants and stem cell support (obtained from allogeneic or autologous peripheral blood or marrow) with associated high dose chemotherapy are covered subject to the Plan Coinsurance when preauthorized by GHO and performed in a GHO Facility after the annual Deductible is satisfied. Covered Services must be directly associated with, and occur at the time of, the transplant.

- Evaluation testing to determine recipient candidacy,
- Matching tests,
- Hospital charges,
- Procurement center fees,
- Professional fees,
- Travel costs for a surgical team,
- Excision fees,
- Donor costs for a covered organ recipient are limited to procurement center fees, travel costs for a surgical team and excision fees,
- Follow-up services for specialty visits,
- Rehospitalization, and
- Maintenance medications.

Under the Community Provider option, transplant services must be authorized in advance by GHO.

Organ Transplant Recipient: All services and supplies related to the organ transplant for the Enrollee receiving the organ, including transportation to and from GHO Facilities (beyond that distance the Enrollee would normally be required to travel for most hospital services), are covered in accordance with the transplant benefit language, provided the Enrollee has been accepted into the treating facility's transplant program and continues to follow that program's prescribed protocol.

Organ Transplant Donor: The costs related to organ removal, as well as the cost of treating complications directly resulting from the surgery, are covered, provided the organ recipient is an Enrollee under this agreement, and provided the donor is not eligible for coverage under any other health care plan or government-funded program.

Benefit Limitations: Transplants that are not preauthorized or are not performed in a GHO Facility are not covered. Benefits for costs relating to donor searches are provided only for allogeneic bone marrow transplants. Direct medical costs for up to 15 searches are covered. No other benefits are provided for services relating to locating a donor for organ transplants.

19. PHENYLKETONURIA (PKU) SUPPLIMENTS

Phenylketonuria supplements are covered subject to the Plan Coinsurance for treatment of this disorder after the annual Deductible is satisfied.

Outpatient total parenteral nutritional therapy, when Medically Necessary and in accordance with medical criteria as established by GHO, is covered subject to the Plan Coinsurance after the annual Deductible is satisfied.

Outpatient elemental formulas for malabsorption, when Medically Necessary and in accordance with medical criteria as established by GHO, are covered subject to the Plan Coinsurance after the annual Deductible is satisfied. Formulas for access problems are excluded.

Equipment and supplies for the administration of enteral and parenteral therapy is covered under Durable Medical Equipment and Supplies (for home use) and Prostheses.

Dietary formulas, oral nutritional supplements, special diets and prepared foods/meals, except treatment of phenylketonuria (PKU) and total parenteral and enteral nutritional therapy as set forth above, are excluded.

20. PHYSICAL, OCCUPATIONAL, SPEECH AND MASSAGE THERAPIES (Rehabilitation Services)

Treatment that is prescribed by the enrollee's PCP and is provided by a plan-designated provider and is approved by Group Health is covered for inpatient and outpatient physical, occupational, speech, and massage therapy services to restore or improve physical functioning due to a covered illness or injury. Inpatient rehabilitation therapy services are covered to a maximum of 60 days per calendar year, subject to the Plan Coinsurance after the annual deductible is satisfied. Outpatient therapy services are covered to a maximum of 60 visits for all therapies combined per calendar year, subject to the Plan Coinsurance after the annual deductible is satisfied.

The enrollee will not be eligible for both the "Neurodevelopmental Therapy" benefit and this benefit for the same services for the same condition.

21. PRESCRIPTION DRUGS, INSULIN AND DIABETIC SUPPLIES

This benefit, for purposes of creditable coverage, is actuarially equal to or greater than the Medicare Part D prescription drug benefit. Eligible Enrollees who are also eligible for Medicare Part D pharmacy benefits can remain covered under the Agreement and not be subject to Medicare-imposed late enrollment penalties should they decide to enroll in a Medicare Part D pharmacy plan at a later date. An Enrollee who discontinues coverage under the Agreement must meet eligibility requirements in order to re-enroll.

Retail
Up to a 30 day supply or refill of outpatient prescription drugs, insulin, and disposable diabetic supplies necessary for the treatment of diabetes, is covered subject to the Copayments explained in the Allowances Schedule, or the actual cost of the prescription if less than the Copayment (annual Deductible applies). The Enrollee may obtain up to a 90 day supply for an individual prescription at one filling, with the payment of the 90-day supply Copayments explained in the Allowances Schedule, subject to the annual Deductible. In order to receive a quantity sufficient for a 90 day supply, the prescription should specify that each fill is for 90 days or longer. Prescriptions written for a quantity sufficient for only a 30 day supply with the ability to refill for an additional 30 days or longer, may be limited to a 30 day supply per fill. Single-dose, long-acting drugs, and drugs packaged or dispensed in a single unit (such as inhalers) are subject to a single Copayment.

Generic drugs will be dispensed unless a suitable generic is not available. Generic drugs are defined as a drug that is the pharmaceutical equivalent to one or more brand name drugs. Such generic drugs have been approved by the Food and Drug Administration as meeting the same standards of safety, purity, strength and effectiveness as the brand name drug. Brand name drugs are defined as a prescription drug that has been patented and is only available through one manufacturer. Approved drugs include federal legend drugs and insulin when prescribed by a MHCN Provider. In the event the Enrollee elects to purchase brand name drugs instead of the generic equivalent (if available), or if the Enrollee elects to purchase a different brand name or generic drug than that prescribed by the Enrollee's Provider, and it is not determined to be Medically Necessary, the Enrollee will also be subject to payment of the additional amount above the applicable pharmacy Copayment. Any exclusion of drugs and medicines will also exclude their administration.

Formulary: A list of preferred pharmaceutical products that GHO, working with pharmacists and physicians, has developed to encourage greater efficiency in the dispensing of prescription drugs without sacrificing quality. Contact GHO Customer Service to request a copy of the formulary.

GHO reserves the right to limit the quantity fill on an initial prescription to evaluate the therapeutic outcomes. GHO also reserves the right to limit the prescription quantity of any drug when a restricted dosage would constitute medically prudent and efficacious treatment.

Exception and Appeal Process: See Filing a Complaint or Appeal section on page 50.

Drugs must be prescribed by a GHO Provider and purchased at a GHO pharmacy. A limited supply of prescription drugs purchased from a non-GHO Facility or pharmacy is covered subject to the applicable pharmacy Copayment when dispensed or prescribed in connection with covered Emergency treatment.

Mail-Order Benefit
Covered medications are available through the mail order program subject to the Copayment set forth below when prescribed by a GHO Provider. The Enrollee must

call the 24-hour Pharmacy Line at 1-800-245-7979 and leave a voicemail order. The Enrollees refill will be sent to them with no shipping charge. Allow 10 days for delivery. Covered prescription drugs include, but are not limited to medications used on a regularly scheduled basis for the treatment of chronic medical conditions such as hypertension, diabetes or asthma. Also covered through the mail order program are birth control pills; insulin; diabetic supplies including needles, syringes, lancets and test strips. Dosage and quantity limits will follow the formulary guidelines and/or standard medical practice. The quantity of new prescriptions may be limited to evaluate the therapeutic outcomes. GHO also reserves the right to limit the prescription quantity of any drug when a restricted dosage would constitute medically prudent and efficacious treatment.

Pharmacy Online
This service is available for refills only. Enrollees can order drugs, over-the-counter products, and special medical items on the GHO web site and have them delivered free of charge. To use this service, go to the MyGroupHealth home page at www.ghc.org. The Enrollee must register with MyGroupHealth and complete an ID verification process. Once the Enrollee has done that, they'll find a link to Pharmacy Online every time they log in to the MyGroupHealth home page.

Prescription drug Copayments do not apply to the annual Out-of-Pocket Limit.

Off-Label Drugs: FDA-approved drugs used for off-label indications will be provided only if recognized as effective for treatment 1) in one of the standard reference compendia; 2) in the majority of relevant peer-reviewed medical literature if not recognized in one of the standard reference compendia; or 3) by the federal Secretary of Health and Human Services. No benefits will be provided for any drug when the FDA has determined its use to be contra-indicated.

a. "Off-label" means the prescribed use of a drug which is other than that stated in its FDA-approved labeling.

b. "Standard Reference Compendia" means:

(1) The American Hospital Formulary Service-Drug Information;
(2) The American Medical Association Drug Evaluation;
(3) The United States Pharmacopoeia-Drug Information; or
(4) Other authoritative compendia as identified from time to time by the federal Secretary of Health and Human Services.

c. "Peer-reviewed Medical Literature" means scientific studies printed in journals or other publications in which original manuscripts are published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts. Peer-reviewed medical literature does not include in-house publications of pharmaceutical manufacturing companies.

The Enrollee's Right to Safe and Effective Pharmacy Services: State and federal laws establish standards to assure safe and effective pharmacy services, and to guarantee Enrollees' right to know what drugs are covered under this Agreement and what coverage limitations are in this Agreement. Enrollees who

would like more information about the drug coverage policies under this Agreement, or have a question or a concern about their pharmacy benefit, may contact GHO at (206) 901-4636 or 1-888-901-4636.

Enrollees who would like to know more about their rights under the law, or think any services received while enrolled may not conform to the terms of this Agreement, may contact the Washington State Office of Insurance Commissioner at 1-800-562-6900. Enrollees who have a concern about the pharmacists or pharmacies serving them, may call the Washington State Department of Health at 1-800-525-0127.

22. PREVENTIVE SERVICES

Preventive care (well care) services for health maintenance in accordance with the well care schedule established by GHO for the following:

MHCN: Routine mammography screening, physical examinations and routine laboratory tests for cancer screening including prostate screening in accordance with the well care schedule established by GHO and the Patient Protection and Affordable Care Act of 2010, and immunizations and vaccinations listed as covered in the GHO drug formulary (approved drug list). A fee may be charged for health education programs. The well care schedule is available in Group Health clinics, by accessing GHO's website at www.ghc.org, or upon request.

Covered Services provided during a preventive care visit, which are not in accordance with the GHO well care schedule, may be subject to Cost Shares.

Community Provider: Routine mammography screening.

23. RADIATION AND CHEMOTHERAPY SERVICES

Radiation and Chemotherapy services are covered subject to the Plan Coinsurance, after the annual Deductible is satisfied

24. PLASTIC AND RECONSTRUCTIVE SERVICES

Plastic and reconstructive services are covered as set forth below subject to the Plan Coinsurance after the annual Deductible is satisfied.

1. Correction of a congenital disease or congenital anomaly. A congenital anomaly will be considered to exist if the Enrollee's appearance resulting from such condition is not within the range of normal human variation.

2. Correction of a Medical Condition following an injury or resulting from surgery covered by GHO which has produced a major effect on the Enrollee's appearance, when in the opinion of GHO's Medical Director, or his/her designee, such services can reasonably be expected to correct the condition.

3. Reconstructive surgery and associated procedures, including internal breast prostheses, following a mastectomy, regardless of when the mastectomy was performed.

Enrollees will be covered for all stages of reconstruction on the non-diseased breast to make it equivalent in size with the diseased breast.

Complications of covered mastectomy services, including lymphedemas, are covered.

Excluded: cosmetic services, including treatment for complications resulting from cosmetic surgery, and complications of noncovered surgical services.

25. SKILLED NURSING FACILITY (SNF)

Skilled nursing care in a GHO-approved skilled nursing facility when full-time skilled nursing care is necessary in the opinion of the attending physician, is covered up to 150 days per calendar year, subject to the Plan Coinsurance, after the annual Deductible is satisfied. Under the Community Provider option, skilled nursing care must be authorized in advance by GHO.

Additional coverage may be approved by GHO if the stay is in lieu of hospitalization.

When prescribed by the Enrollee's physician, such care may include room and board; general nursing care; drugs, biologicals, supplies and equipment ordinarily provided or arranged by a skilled nursing facility; and short-term physical therapy, occupational therapy and restorative speech therapy.

Excluded: personal comfort items such as telephone and television, rest cures and custodial, domiciliary or convalescent care.

26. SPINAL MANIPULATIONS

Manipulative therapy of the spine and extremities are covered subject to the Plan Coinsuranceafter the annual Deductible is satisfied.

Supportive care rendered primarily to maintain the level of correction already achieved, care rendered primarily for the convenience of the Enrollee, care rendered on a non-acute, asymptomatic basis and charges for any other services that do not meet GHO clinical criteria as Medically Necessary are excluded.

27. TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ)

Medical services for the treatment of temporomandibular joint (TMJ) disorders are covered at 50% up to $1,000 per calendar year after the annual Deductible is satisfied. Radiology services and TMJ specialist services are also covered.

Excluded: treatment for cosmetic purposes, bite blocks, dental services including orthodontic therapy, or any orthognathic (jaw) surgery in the absence of a diagnosis of TMJ, severe obstructive sleep apnea or congenital anomaly. Any hospitalizations related to these exclusions is also excluded.

28. TOBACCO CESSATION SERVICES

Services related to tobacco cessation are covered, limited to:

Participation in individual or group counseling;
Educational materials; and
Approved pharmacy products.

MHCN: Covered in full for counseling; approved pharmacy products covered in full when prescribed as part of the GHO-designated tobacco cessation program and dispensed through the GHO designated mail order service.

Community Provider: Counseling covered subject to the plan coinsurance after the annual deductible is satisfied; approved pharmacy products covered subject to the prescription drug cost share.

29. VISION CARE (ROUTINE)

MHCN: Routine eye examinations and refractions received at a MHCN Facility once every twelve (12) consecutive months, or when Medically Necessary. Routine eye examinations to monitor Medical Conditions are covered subject to the Plan Coinsurance, after the annual Deductible is satisfied, as often as necessary upon recommendation of a MHCN Provider.

Contact lenses for eye pathology, including contact lens exam and fitting, are covered subject to the Plan Coinsurance after the annual Deductible is satisfied. When dispensed through MHCN Facilities, one contact lens per diseased eye in lieu of an intraocular lens, including exam and fitting, is covered for Enrollees following cataract surgery performed by a MHCN Provider, provided the Enrollee has been continuously covered by GHO since such surgery.

Replacement of lenses for eye pathology, including following cataract surgery, will be covered only once within a twenty-four (24) month period and only when needed due to a change in the Enrollee's Medical Condition. Replacement for loss or breakage is subject to the Lenses and Frames benefit Allowance.

Community Provider: Eye examinations for eye pathology when Medically Necessary. Routine eye examinations are covered once every twelve (12) consecutive months or when Medically Necessary.

One contact lens per diseased eye in lieu of an intraocular lens, including exam and fitting, is covered for Members following cataract surgery, provided the Member has been continuously covered by GHO since such surgery. Replacement of lenses for eye pathology, including following cataract surgery, will be covered only once within a twenty-four (24) month period and only when needed due to a change in the Member's Medical Condition.

Excluded: routine eye examinations and refractions, eyeglasses, contact lenses and services related to their fitting, orthoptic therapy (i.e., eye training), evaluations and surgical procedures to correct refractions not related to eye pathology and

complications related to such procedures, and contact lens fittings and related examinations not related to eye pathology, except as set forth above.

Lenses and Frames

Not subject to the annual Deductible.

Benefits may be used toward the following in any combination, over the benefit period, until the benefit maximum of $150 once every twenty-four (24) months is exhausted:

- Eyeglass frames
- Eyeglass lenses (any type) including tinting and coating
- Corrective industrial (safety) lenses
- Sunglass lenses and frames when prescribed by an eye care provider for eye protection or light sensitivity
- Corrective contact lenses in the absence of eye pathology, including associated fitting and evaluation examinations
- Replacement frames, for any reason, including loss or breakage
- Replacement contact lenses
- Replacement eyeglass lenses

The benefit period begins on the date services are first obtained and continues for twenty-four (24) months.

Excluded: orthoptic therapy (i.e. eye training), evaluations and surgical procedures to correct refractions not related to eye pathology and complications related to such procedures.

30. WEIGHT CONTROL

Bariatric surgery and related hospitalizations are covered when GHO criteria are met.

MHCN: Covered subject to the applicable Plan Coinsurance after the annual Deductible is satisfied.

Community Provider: Not covered.

Excluded: bariatric surgery if you had bariatric surgery within the past 10 years, pre and post surgical nutritional counseling and related weight loss programs, prescribing and monitoring of drugs, structured weight loss and/or exercise programs and specialized nutritional counseling.

Benefit Exclusions and Limitations

In addition to any exclusion listed in the previous pages, the plan does not cover the following:

1. Services not provided by a GHO Provider or obtained in accordance with GHO's standard Authorization requirements, except for Emergency care or as covered under coordination of benefits provisions.
2. Non-participating providers are not covered inside or outside of the Service Area except for: emergencies; or when otherwise specifically provided.
3. Experimental or investigational services, supplies and drugs.
4. That additional portion of a physical exam beyond a routine physical that is specifically required for the purpose of employment, travel, immigration, licensing or insurance and related reports.
5. Services or supplies for which no charge is made, or for which a charge would not have been made if the Enrollee had no health care coverage or for which the Enrollee is not liable; services provided by a family member.
6. Drugs and medicines not prescribed by a GHO Provider, except for Emergency treatment.
7. Cosmetic services or supplies except: to restore function, for reconstructive surgery of a congenital anomaly, or reconstructive breast surgery following a mastectomy necessitated by disease, illness or injury.
8. Skilled nursing facility confinement or residential mental health treatment programs for mental health conditions, mental retardation, or for care which is primarily domiciliary, convalescent or custodial in nature.
9. Conditions caused by or arising from acts of war.
10. Dental care including:
    - orthognathic surgery except for congenital anomalies;
    - myofascial pain dysfunction (MPD); and
    - dental implants.
11. Sexual reassignment surgery, services and supplies.
12. Procedures and services to reverse a therapeutic or nontherapeutic sterilization.
13. Testing and treatment of infertility and sterility, including but not limited to artificial insemination and in vitro fertilization.
14. Services and supplies provided solely for the comfort of the Enrollee, except palliative care provided under the "Hospice Care" benefit.
15. Coverage for an organ donor, unless the recipient is an Enrollee under this Agreement.
16. **Weight Control and Obesity Treatment.**

    Non-surgical: Any weight loss or weight control programs, treatments, services, or supplies, even when prescribed by a physician, including, but not limited to, prescription and over-the-counter drugs, exercise programs (formal or informal), exercise equipment, or nutritional counseling (except as specified in the Diabetic Education benefit in this Certificate of Coverage). Travel expenses associated with non-surgical or surgical weight control or obesity services.

    Surgical: Surgery for dietary or weight control, and any direct or non-direct complications arising from such non-covered surgeries, whether prescribed or recommended by a physician, including surgeries such as:

1. mini-gastric banding (gastric bypass using a Billroth II type of anastomosis)
2. distall gastric bypass (long limb gastric bypass)
3. billopancreatic bypass and billopancreatic with duodenal switch
4. jejunoileal bypass
5. gastric stapling or liposuction
6. removal of excess skin
7. bariatric surgery if you had bariatric surgery within the past 10 years
8. vertical sleeve procedure

The surgical exclusion for weight control and obesity treatment will not apply to preauthorized, Medically Necessary bariatric surgery of adult morbid obesity as specifically set forth in this Certificate of Coverage and the health plan's Bariatric Management criteria. More than one bariatric surgery for Enrollees will not be covered under the PEBB program.

17. Evaluation and treatment of learning disabilities, including dyslexia, except as provided for neurodevelopmental therapies.
18. Orthoptic therapy (eye training); vision services, except as specified for vision care. Surgery to improve the refractive character of the cornea including any direct complications.
19. Orthotics, except foot care appliances for prevention of complications associated with diabetes.
20. Routine foot care.
21. Services for which an Enrollee has a contractual right to recover cost under homeowner's or other no-fault coverage, to the extent that it can be determined that the Enrollee received double recovery for such services.
22. Any medical services or supplies not specifically listed as covered.
23. Direct complications arising from excluded services.
24. Pharmaceutical treatment of impotence or sexual dysfunction.
25. When Medicare coverage is primary, charges for services or supplies provided to Enrollees through a "Private Contract" agreement with a physician or practitioner who does not provide services through the Medicare program.
26. Replacement of lost or stolen medications.
27. Recreation therapy.
28. Follow-up services related to a non-Covered Service.
29. Complications of non-Covered Services.
30. Services covered by the national health plan of any other country.
31. Services that:

    - You (or a covered family member) need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
    - OWCP or a similar agency pays for through a third party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

    Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care, up to the benefit limits of this Plan. You must use our providers.

How To Obtain Care Within the Service Area

Accessing Care

Members are entitled to Covered Services from:

- GHO's Managed Health Care Network, referred to as "MHCN,"
- Community Providers or Preferred Community Providers, or
- Qualified worldwide providers (emergent/urgent care only). A qualified worldwide provider is a provider meeting all applicable licensing and certification requirements established in the state or country where the provider practices.

Members may choose either health care delivery option at any time during or for differing episodes of illness or injury, except during a scheduled inpatient admission.

Benefits paid under one option will not be duplicated under the other option.

Under the Agreement, the level of benefits available for services received at the MHCN is generally greater than the level of benefits available for services received from Community Providers. In order for services to be covered at the higher benefit level, services must be obtained by MHCN Providers at MHCN Facilities, except for Emergency care and care pursuant to an Authorization.

All inpatient admissions prescribed by a Community Provider must be authorized in advance by GHO. Members may refer to Sections IV.A. and IV.C. for more information about inpatient admissions.

Personal Physicians

GHO recommends that Enrollees select a MHCN Personal Physician in their Service Area from the participating Provider Directory when enrolling under the Agreement. One Personal Physician may be selected for the entire family or a different Personal Physician may be selected for each family member.

The Enrollee may change from one Personal Physician to another by contacting one of GHO's Customer Service representatives, or accessing the GHO website at www.ghc.org. The change will be made within 24 hours of the receipt of the request if the selected physician's caseload permits. GHO's 24 hour Consulting Nurse Service provides round-the-clock health care advice by phone. Many facilities also have urgent care hours in addition to regular hours.

The Enrollee must notify their new Personal Physician that they have been receiving services from a specialist, so the Enrollee's Personal Physician can make arrangements for them to continue to receive specialty care.

In the case that the Enrollee's Personal Physician no longer participates in GHO's network, the Enrollee will be provided access to the Personal Physician for up to sixty (60) days following a written notice offering the Enrollee a selection of new Personal Physicians from which to choose.

Specialty Care

Specialty care will be provided only when referred by the Enrollee's Personal Physician and authorized in advance and in writing by GHO except as noted under "Preauthorization Procedures." All care must be received from GHO Providers, except for Emergency care.

If the Enrollee needs specialized care, the Enrollee's Personal Physician will refer them to one of GHO's specialists. GHO specialists are unique because they work closely with the Enrollee's regular Personal Physician. They are part of the same team. The Enrollee's provider will know which specialist at GHO will have the expertise to match the Enrollee's particular situation. In some parts of the GHO Service Area, Enrollees are referred to carefully selected specialists in the community. If the Enrollee has a complex or serious medical or mental health condition, they may request a standing Authorization from their GHO Personal Physician for specialist services.

Preauthorization Procedures

Enrollees are required to use GHO Providers and GHO Facilities, except on prior written Authorization by GHO, or for an Emergency. All inpatient services and use of ambulatory surgical centers in conjunction with any dental procedure require preauthorization by GHO.

Specialty care will be provided only when authorized in advance and in writing by the Enrollee's Personal Physician, with the exception of self-referred manipulative therapy, Women's Health Care specialists as noted below under "Direct Access for Women's Health Care," and visits with MHCN-Designated Specialists.

MHCN-Designated Specialists

Enrollees may make appointments directly with MHCN-Designated Specialists at GHO-owned or -operated medical centers without an Authorization from their Personal Physician. The following specialty care areas are available from MHCN-Designated Specialists: allergy, audiology, cardiology, chemical dependency, chiropractic/manipulative therapy, dermatology, gastroenterology, general surgery, hospice, manipulative therapy, mental health, nephrology, neurology, obstetrics and gynecology, occupational medicine*, oncology/hematology, ophthalmology, optometry, orthopedics, otolaryngology (ear, nose, and throat), physical therapy*, smoking cessation, speech/language and learning services*, and urology.

Direct Access For Women's Health Care

Female Enrollees may see the following GHO Providers of women's health care services without an Authorization from their Personal Physician for Medically Necessary services:

- General and Family Practitioner,
- Physician's Assistant,
- Gynecologist,
- Certified Nurse Midwife,
- Doctor of Osteopathy,

- Obstetrician,
- Advanced Registered Nurse Practitioner
- Licensed Midwife
- Pediatrician

Women's health care services include:

- Medically Necessary maternity care,
- Covered reproductive health services,
- Preventive care and general examinations,
- Gynecological care, and
- Medically Necessary follow-up visits for the above services.

If the Enrollee's chosen provider diagnoses a condition that requires an Authorization to other specialists or hospitalization, the Enrollee or his/her chosen provider must obtain preauthorization and care coordination in accordance with applicable GHO requirements.

Within the MHCN, women's health care services are covered as if the Enrollee's Personal Physician had been consulted, and are subject to all applicable Copayments, Coinsurances and Deductibles. Women's health care services obtained from a Community Provider are covered at the Community Provider benefit level.

A listing of consulting specialists, women's health care providers, and MHCN-Designated Specialists is available by contacting GHO Customer Service at (206) 901-4636 (or 1-888-901-4636), or by accessing GHO's website at www.ghc.org.

Second Opinions

Enrollees or the Enrollee's family may request an Authorization from the Enrollee's Personal Physician, or may visit a MHCN-Designated Specialist, for a second opinion. When second opinions are requested or indicated, they are provided by MHCN Providers and are covered when **authorized in advance,** or when obtained from a MHCN-Designated Self-Referral Specialist. Coverage is determined by the Enrollee's medical coverage plan, therefore, coverage for the second opinion does not imply that the services or treatments recommended will be covered.

Referral for a second opinion does not imply that GHO will refer the Enrollee back to the physician providing the second opinion for the recommended treatment. Any diagnostic or therapeutic services must be initiated by the referring MHCN Provider. Services, drugs, devices, etc., prescribed or recommended as a result of the Consultation are not covered unless included as covered under this Agreement. The Enrollee may also access a second opinion from a Community Provider, subject to the Community Provider benefit level.

Individual Case Management

When Medically Necessary and cost-effective, GHO may provide alternative benefits for Covered Services to an Enrollee on a case-by-case basis.

In order for GHO to provide alternative services, a written agreement that specifies services, supplies, benefits and limitations must be signed by the Enrollee, the Personal Physician and GHO. GHO reserves the right to terminate these extended benefits when the services are no longer Medically Necessary, cost-effective, feasible, or at any time by sending written notice to the Enrollee.

Home Health Care Alternative to Hospitalization

When provided at equal or lower cost, the benefits of this Agreement will be available for home health care instead of hospitalization or other institutional care when furnished by a GHO home health, hospice, or home care agency. Substitution of less expensive or less intensive services will be made only with the consent of the Enrollee, and when the Enrollee's physician or other GHO health care provider advises that the services will adequately meet the Enrollee's needs. GHO will base the decision to substitute less expensive or less intensive services on the Enrollee's individual medical needs. GHO may require a written treatment plan which is approved by the GHO Provider. Care will be covered on the same basis as for the institutional care substituted. Benefits will be applied to the maximum plan benefit payable for hospital or other institutional expenses, and will be subject to any applicable Deductible, Copayment and Coinsurance amounts required under this Agreement.

Emergency Care

Emergency Services

The Enrollee must notify GHO within 24 hours of receiving services, or as soon as is medically reasonable, to ensure maximum coverage.

When the Enrollee is medically stabilized, GHO may require the Enrollee to be transferred to the care of a MHCN Provider. If the Enrollee refuses to transfer to the specified facility, all costs incurred after the date the transfer could have occurred will be the Enrollee's responsibility to pay.

Under the MHCN option, urgent care is covered at MHCN medical centers, MHCN urgent care clinics, or MHCN Providers' offices. Urgent care received at any hospital emergency department is not covered unless authorized in advance by GHO.

World-Wide Emergency Care – Under the Community Provider option, the Enrollee or an Enrollee's family member must call the GHO Notification Line within 24 hours or as soon thereafter as is reasonably possible following the emergency.

OUTSIDE OF SERVICE AREA

Enrollees must permanently reside within the GHO Service Area in order to enroll under this Agreement.

Reciprocity

PEBB Enrollees who are temporarily outside the GHO Service Area may have access to care with carriers that participate in reciprocity agreements with GHO. If the Enrollee plans to travel and wishes to obtain more information about the benefits available to them, they may call GHO's Customer Service Center at 1-888-901-4636.

How to Submit Claims

Claims for benefits may be made before or after services are obtained. To make a claim for benefits under this Agreement, an Enrollee (or the Enrollee's authorized representative) must contact GHO Customer Service, or submit a claim for reimbursement as described below. Other inquiries, such as asking a health care provider about care or coverage, or submitting a prescription to a pharmacy, will not be considered a claim for benefits.

If an Enrollee receives a bill for Covered Services, the Enrollee must, within 60 days of the service date, or as soon thereafter as is reasonably possible, either a) contact GHO Customer Service to make a claim or b) pay the bill and submit a claim for reimbursement of Covered Services to GHO, P.O. Box 34585, Seattle, WA 98124-1585. In no event, except in the absence of legal capacity, shall a claim be accepted later than one (1) year from the service date.

GHO will generally process claims for benefits within the following timeframes after GHO receives the claims:

- Pre-service claims – within 15 days.
- Claims involving urgently needed care – within 72 hours
- Concurrent care claims – within 24 hours
- Post-service claims – within 30 days.

Timeframes for pre-service and post-service claims can be extended by GHO for up to an additional fifteen (15) days. Enrollees will be notified in writing of such extension prior to the expiration of the initial timeframe.

Release of Information

Enrollees may be required to provide GHO or the HCA with information necessary to determine eligibility, administer benefits or process claims. This could include, but is not limited to, medical records. Benefits could be denied if Enrollees fail to provide such information when requested. Know that GHO does not disclose medical information related to the Enrollee's mental health, genetic testing results, and drug and alcohol abuse treatment records to third parties without the Enrollee's special consent/authorization or as required or permitted by law.

When the Enrollee has Other Medical Coverage

A. Coordination of Benefits

Note: If a Member participating in a Health Savings Account has other health care coverage (in addition to the coverage provided under the Agreement), the tax deductibility of Health Savings Account contributions may be affected.

Please contact the Health Savings Account trustee or administrator regarding questions about requirements for Health Savings Accounts.

The coordination of benefits (COB) provision applies when an Enrollee has health care coverage under more than one plan. PEBB benefits will not be coordinated with any individual health care plan that covers the Enrollee. Plan is defined below.

The order of benefit determination rules govern the order in which each plan will pay a claim for benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits according to its policy terms without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan must pay an amount which, together with the payment made by the primary plan, totals the higher of the allowable expenses. In no event will a secondary plan be required to pay an amount in excess of its maximum benefit plus accrued savings.

If the Enrollee is covered by more than one health benefit plan, the Enrollee or the Enrollee's provider should file all the Enrollee's claims with each plan at the same time. If Medicare is the Enrollee's primary plan, Medicare may submit the Enrollee's claims to the Enrollee's secondary carrier.

1. Definitions.

a. Plan. A plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for Enrollees of a Group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts. However, if COB rules do not apply to all contracts, or to all benefits in the same contract, the contract or benefit to which COB does not apply is treated as a separate plan.

1) Plan includes: group, blanket disability insurance contracts and group contracts issued by health care service contractors or health maintenance organizations (HMO), closed panel plans or other forms of group coverage; medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.

2) Plan does not include: hospital indemnity or fixed payment coverage or other fixed indemnity or fixed payment coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; automobile insurance policies required by statute to provide medical benefits; Medicare supplement policies; Medicaid coverage; or coverage under other federal governmental plans; unless permitted by law.

Each contract for coverage under subsection 1) or 2) is a separate plan. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

b. This plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

c. The order of benefit determination rules determine whether this plan is a primary plan or secondary plan when the Enrollee has health care coverage under more than one plan.

   When this plan is primary, it determines payment for its benefits first before those of any other plan without considering any other plan's benefits. When this plan is secondary, it determines its benefits after those of another plan and must make payment in an amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim equal 100% of the total allowable expense for that claim. This means that when this plan is secondary, it must pay the amount which, when combined with what the primary plan paid, totals 100% of the highest allowable expense. In addition, if this plan is secondary, it must calculate its savings (its amount paid subtracted from the amount it would have paid had it been the primary plan) and record these savings as a benefit reserve for the covered Enrollee. This reserve must be used by the secondary plan to pay any allowable expenses not otherwise paid, that are incurred by the covered person during the claim determination period.

d. Allowable Expense. Allowable expense is a health care expense, coinsurance or copayments and without reduction for any applicable deductible that is covered at least in part by any plan covering the person. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense that is not covered by any plan covering the Enrollee is not an allowable expense.

   The following are examples of expenses that are not allowable expenses:

   1) The difference between the cost of a semi-private hospital room and a private hospital room is not an allowable expense, unless one of the plans provides coverage for private hospital room expenses.
   2) If an Enrollee is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.
   3) If an Enrollee is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.
   4) An expense or a portion of an expense that is not covered by **any of the plans** covering the person is not an **allowable expense.**

e. Closed panel plan is a plan that provides health care benefits to covered persons in the form of services through a panel of providers who are primarily employed by the plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

f. Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

2. Order of Benefit Determination Rules.

When an Enrollee is covered by two or more plans, the rules for determining the order of benefit payments are as follows:

a. The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other plan.

b. Except as provided below, a plan that does not contain a coordination of benefits provision that is consistent with this chapter is always primary unless the provisions of both plans state that the complying plan is primary.

Coverage that is obtained by virtue of membership in a Group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage is excess to any other parts of the plan provided by the Subscriber. Examples include major medical coverage's that are superimposed over hospital and surgical benefits, and insurance type coverage's that are written in connection with a closed panel plan to provide out-of-network benefits.

c. A plan may consider the benefits paid or provided by another plan in calculating payment of its benefits only when it is secondary to that other plan.

d. Each plan determines its order of benefits using the first of the following rules that apply:

1) Non-Dependent or Dependent. The plan that covers the Enrollee other than as a Dependent, for example as an employee, member, policyholder, Subscriber or retiree is the primary plan and the plan that covers the Enrollee as a Dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the Enrollee as a Dependent, and primary to the plan covering the Enrollee as other than a Dependent (e.g., a retired employee), then the order of benefits between the two plans is reversed so that the plan covering the Enrollee as an employee, member, policyholder, Subscriber or retiree is the secondary plan and the other plan is the primary plan.

2) Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one plan the order of benefits is determined as follows:

a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
   - The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or
   - If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.

b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
   (1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods commencing after the plan is given notice of the court decree;
   (2) If a court decree states one parent is to assume primary financial responsibility for the dependent child but does not mention responsibility for health care expenses, the plan of the parent assuming financial responsibility is primary;
   (3) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of a) above determine the order of benefits;
   (4) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subsection a) above determine the order of benefits; or
   (5) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
      - The plan covering the custodial parent, first;
      - The plan covering the spouse of the custodial parent, second;
      - The plan covering the non-custodial parent, third; and then
      - The plan covering the spouse of the non-custodial parent, last.

c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the provisions of subsection a) or b) above determine the order of benefits as if those individuals were the parents of the child.

3) Active employee or retired or laid-off employee. The plan that covers an Enrollee as an active employee, that is, an employee who is neither laid off nor retired, is the primary plan. The plan covering that same Enrollee as a retired or laid off employee is the secondary plan. The same would hold true if an Enrollee is a Dependent of an active employee and that same Enrollee is a Dependent of a retired or laid-off employee. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under section d 1) can determine the order of benefits.

4) COBRA or State Continuation Coverage. If an Enrollee whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the Enrollee as an employee, member, Subscriber or retiree or covering the Enrollee as a Dependent of an employee, member, Subscriber or retiree is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under section d 1) can determine the order of benefits.

5) Longer or shorter length of coverage. The plan that covered the Enrollee as an employee, member, Subscriber or retiree longer is the primary plan and the plan that covered the Enrollee the shorter period of time is the secondary plan.

6) If the preceding rules do not determine the order of benefits, the allowable expenses must be shared equally between the plans meeting the definition of plan. In addition, this plan will not pay more than it would have paid had it been the primary plan.

3. Effect on the Benefits of this Plan.

When this plan is secondary, it must make payment in an amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim equal one hundred percent of the total allowable expense for that claim. However, in no event shall the secondary plan be required to pay an amount in excess of its maximum benefit plus accrued savings. In no event should the Enrollee be responsible for a deductible amount greater than the highest of the two deductibles. Total allowable expense is the highest allowable expenses of the primary plan or the secondary plan. In addition, the secondary plan must credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

4. Right to Receive and Release Needed Information.

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. GHO may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the Enrollee claiming benefits. GHO need not tell, or get the consent of, any Enrollee to do this. Each Enrollee claiming benefits under this plan must give GHO any facts it needs to apply those rules and determine benefits payable.

5. Facility of Payment.

If payments that should have been made under this plan are made by another plan, GHO has the right, at its discretion, to remit to the other plan the amount it

determines appropriate to satisfy the intent of this provision. The amounts paid to the other plan are considered benefits paid under this plan. To the extent of such payments, GHO is fully discharged from liability under this plan.

6. **Right of Recovery.**

   GHO has the right to recover excess payment whenever it has paid allowable expenses in excess of the maximum amount of payment necessary to satisfy the intent of this provision. GHO may recover excess payment from any person to whom or for whom payment was made or any other issuers or plans.

   Questions about Coordination of Benefits? Contact the State Insurance Department.

When a Third Party Is Responsible for Injury or Illness (Subrogation)

The benefits under this Agreement will be available to an Enrollee for injury or illness caused by another party, subject to the exclusions and limitations of this Agreement. If GHO provides benefits under this Agreement for the treatment of the injury or illness, GHO will be subrogated to any rights that the Enrollee may have to recover compensation or damages related to the injury or illness and the Enrollee shall reimburse GHO for all benefits provided, from any amounts the Enrollee received or is entitled to receive from any source on account of such injury or illness, whether by suit, settlement or otherwise. This section more fully describes GHO’s subrogation and reimbursement rights.

"Injured Person" under this section means an Enrollee covered by this Agreement who sustains an injury or illness, and any spouse, dependent, or other person or entity that may recover on behalf of such Enrollee (including the estate of the Enrollee and, if the Enrollee is a minor, the guardian or parent of the Enrollee). "GHO's Medical Expenses" means the expense incurred and the value of the services provided by GHO under this agreement for the care or treatment of the injury or illness sustained.

If the injured person’s injuries were caused by a third party giving rise to a claim of legal liability against the third party and/or payment by the third party to the Injured Person and/or a settlement between the third party and the Injured Person, GHO shall have the right to recover GHO's Medical Expenses from any source available to the Injured Person as a result of the events causing the injury, including but not limited to funds available through applicable third party liability coverage and uninsured/underinsured motorist coverage. This right is commonly referred to as "subrogation." GHO shall be subrogated to and may enforce all rights of the Injured Person to the full extent of GHO's Medical Expenses.

GHO’s subrogation and reimbursement rights shall be limited to the excess of the amount required to fully compensate the Injured Person for the loss sustained, including general damages.

Subject to the above provisions, if the Injured Person is entitled to or does receive money from any source as a result of the events causing the injury or illness, (including,

but not limited to, any liability insurance or uninsured/underinsured motorist's funds), GHO's Medical Expenses are secondary, not primary.

The Injured Person and his/her agents shall cooperate fully with GHO in its efforts to collect GHO's Medical Expenses. This cooperation includes, but is not limited to, supplying GHO with information about the cause of injury or illness, any potentially liable third parties, defendants and/or insurers related to the Injured Person's claim and informing GHO of any settlement or other payments relating to the Injured Person's injury. The Injured Person and his/her agents shall permit GHO, at GHO's option, to associate with the Injured Person or to intervene in any legal, quasi-legal, agency or any other action or claim filed. If the Injured Person takes no action to recover money from any source, then the Injured Person agrees to allow GHO to initiate its own direct action for reimbursement or subrogation, including, but not limited to, recovering the full extent of GHO's Medical Expenses directly from the Injured Person.

The Injured Person and his/her agents shall do nothing to prejudice GHO's subrogation and reimbursement rights. The Injured Person shall promptly notify GHO of any tentative settlement with a third party and shall not settle a claim without protecting GHO's interest. If the Injured Person fails to cooperate fully with GHO in recovery of GHO's Medical Expenses, the Injured Person shall be responsible for directly reimbursing GHO for 100% of GHO's Medical Expenses.

To the extent that the Injured Person recovers funds from any source that may serve to compensate for medical injuries or medical expenses, the Injured Person agrees to hold such monies in trust or in a separate identifiable account until GHO's subrogation and reimbursement rights are fully determined and that GHO has an equitable lien over such monies to the full extent of GHO's Medical Expenses and/or the Injured Person agrees to serve as constructive trustee over the monies to the extent of GHO's Medical Expenses.

If this Agreement is not subject to ERISA and reasonable collections costs have been incurred by an attorney for the Injured Person in connection with obtaining recovery, under certain conditions GHO will reduce the amount of reimbursement to GHO by the amount of an equitable apportionment of such collection costs between GHO and the Injured Person. This reduction will be made only if each of the following conditions has been met: (i) the equitable apportionment of attorney fees and costs has been agreed to by GHO prior to settlement or recovery, (ii) the Injured Person's attorney's action has benefited GHO in its recovery, and (iii) the Injured Person's attorney's actions were reasonable and necessary to secure recovery. GHO's share of collection costs (attorney fees and costs combined) is subject to a maximum responsibility of GHO equal to one-third of the amount recovered on behalf of GHO. Under no circumstance will GHO incur collection costs for services which were not reasonably and necessarily incurred to secure recovery or which do not benefit GHO.

If this Agreement is subject to ERISA and reasonable collections costs have been incurred by the Injured Person for the benefit of GHO, under special circumstances, the Injured Person may agree to reduce the amount of reimbursement to GHO by an amount for reasonable and necessary attorney's fees and costs incurred by the Injured Person on behalf of and for the benefit of GHO, but only if such amount is agreed to in writing by GHO prior to settlement or recovery.

To the extent the provisions of this Subrogation and Reimbursement section are deemed governed by ERISA, implementation of this section shall be deemed a part of claims administration under the Agreement and GHO shall therefore have sole discretion to interpret its terms.

Uninsured or Underinsured Motorist Coverage

Any services to the extent benefits under this Agreement are "available" to the Enrollee as defined herein under the terms of any vehicle, homeowner's, property or other insurance policy, whether the Enrollee asserts a claim or not, pursuant to medical coverage, medical "no fault" coverage, Personal Injury Protection coverage or similar medical coverage contained in said policy. For the purpose of this provision, benefits shall be deemed to be "available" to the Enrollee if the Enrollee is a named insured, comes within the policy definition of insured, or otherwise has the right to receive first party benefits under the policy.

The Enrollee and his or her agents must cooperate fully with GHO in its efforts to enforce this provision. This cooperation shall include supplying GHO with information about, or related to, the cause of the injury or illness or the availability of other insurance coverage. The Enrollee and his or her agents shall permit GHO, at GHO's option, to associate with the Enrollee or to intervene in any action filed against any party related to the injury. The Enrollee and his or her agents shall do nothing to prejudice GHO's right to enforce this provision. Failure to fully cooperate, including withholding information regarding the cause of injury or illness or other insurance coverage may result in denial of claims and the Enrollee shall be responsible for reimbursing GHO for expenses incurred and the value of the benefits provided by GHO under this Agreement for the care or treatment of the injury or illness sustained by the enrollee.

GHO shall not enforce this exclusion as to coverage available under uninsured motorist or underinsured motorist coverage until the Enrollee has been made whole, unless the Enrollee fails to cooperate fully with GHO as described above.

If this Agreement is not subject to ERISA and reasonable collections costs have been incurred by an attorney for the Injured Person in connection with obtaining recovery, under certain conditions GHO will reduce the amount of reimbursement to GHO by the amount of an equitable apportionment of such collection costs between GHO and the Injured Person. This reduction will be made only if each of the following conditions has been met: (i) the equitable apportionment of attorney fees has been agreed to by GHO prior to settlement or recovery, (ii) the Injured Person's attorney's action has benefited GHO in its recovery, and (iii) the Injured Person's attorney's actions were reasonable and necessary to secure recovery. GHO's share of collection costs is subject to a maximum responsibility of GHO equal to one-third of the amount recovered on behalf of GHO. Under no circumstance will GHO incur legal fees for services which were not reasonably and necessarily incurred to secure recovery or which do not benefit GHO.

If this Agreement is subject to ERISA and reasonable collections costs have been incurred by the Injured Person for the benefit of GHO, the Injured Person may request and GHO may reduce the amount of reimbursement to GHO by an amount for reasonable and necessary attorney's fees incurred by the Injured Person on behalf of

and for the benefit of GHO, but only if such amount is agreed to by GHO prior to settlement or recovery.

Utilization Management

All benefits under the Agreement are limited to Covered Services that are Medically Necessary and set forth in this Agreement. GHO may review an Enrollee's medical records for the purpose of verifying delivery and coverage of services and items. Based on a prospective, concurrent or retrospective review, GHO may deny coverage if, in its determination, such services are not Medically Necessary. Such determination shall be based on established clinical criteria.

GHO will not deny coverage retroactively for services it has previously authorized and which have already been provided to the Member.

Filing a Complaint or Appeal

The complaint process is available for an Enrollee to express dissatisfaction about customer service or the quality or availability of a health service.

The appeal process is available for an Enrollee to seek reconsideration of a denial of benefits.

Appeals for determination of ineligibility see Eligibility Section page 63.

Complaint Process:

Step 1: The Enrollee should contact the person involved, explain his/her concerns and what he/she would like to have done to resolve the problem. The Enrollee should be specific and make his or her position clear.

Step 2: If the Enrollee is not satisfied or if he/she prefers not to talk with the person involved, the Enrollee should call the department head or the manager of the medical center or department where he/she is having a problem. That person will investigate the Enrollee's concerns. Most concerns can be resolved in this way.

Step 3: If the Enrollee is still not satisfied, he/she should call the GHO Customer Service Center toll free at (888-901-4636). Most concerns are handled by phone within a few days. In some cases the Enrollee will be asked to write down his/her concerns and state what he/she thinks would be a fair resolution to the problem. A Customer Service Representative or Member Quality of Care Coordinator will investigate the Enrollee's concern by consulting with involved staff and their supervisors, and reviewing pertinent records, relevant plan policies and the Enrollees' Rights and Responsibilities statement. This process can take up to thirty (30) days to resolve after receipt of the Enrollee's written statement.

If the Enrollee is dissatisfied with the resolution of the complaint, he/she may contact the Member Quality of Care Coordinator or the Customer Service Center.

Appeals Process:

The U.S. Department of Health and Human Services has designated the Washington State Office of the Insurance Commissioner's Consumer Protection Division as the health insurance consumer ombudsman. The Consumer Protection Division Office can be reached by mail at Washington State Insurance Commissioner, Consumer Protection Division, P.O. Box 40256, Olympia, WA 98504-0256 or toll free at (800) 562-6900. More information about requesting assistance from the Consumer Protection Division Office can be found at http://www.insurance.wa.gov/consumers/health/appeal/Table-of-Contents.shtm.

If the Enrollee requests an appeal of a GHO decision denying benefits, GHO will continue to provide coverage for the disputed benefit pending the outcome of the appeal. If the GHO determination stands, the Enrollee may be responsible for the cost of coverage received during the review period. The decision at the next level of appeal is binding unless other remedies are available under state or federal law. GHO must provide benefits, including making payment on a claim, pursuant to the final external review decision without delay, regardless of whether GHO intends to seek judicial review of the external review decision, and unless or until there is a judicial decision changing the final determination.

Step 1: REGULAR APPEAL PROCESS
What the Enrollee must do: If the Enrollee wishes to appeal a decision denying benefits, he/she must submit a request for an appeal either orally or in writing to the Member Appeals Department, specifying why he/she disagrees with the decision. The appeal must be submitted within 180 days of the denial notice he/she received. Appeals should be directed to GHO's Member Appeals Department, P.O. Box 34593, Seattle WA 98124-1593, toll free (866) 458-5479.

What GHO must do: An Appeals Coordinator will review initial appeal requests. GHO will then notify the Enrollee of its determination or need for an extension of time within fourteen (14) days of receiving the request for appeal. Under no circumstances will the review timeframe exceed thirty (30) days without the Enrollee's written permission.

If the appeal request is for an experimental or investigational exclusion or limitation, GHO will make a determination and notify the Enrollee in writing within twenty (20) working days of receipt of a fully documented request. In the event that additional time is required to make a determination, GHO will notify the Enrollee in writing that an extension in the review timeframe is necessary. Under no circumstances will the review timeframe exceed twenty (20) days without the Enrollee's written permission.

Step 2:
What the Enrollee must do: If the Enrollee is not satisfied with the decision in Step 1 regarding a denial of benefits, or if GHO fails to grant or reject the Enrollee's request within the applicable required timeframe, he/she may request a second level review by an external independent review organization as set forth under Independent Review Organization below. The Enrollee may also choose to pursue review by an appeals committee prior to requesting a review by an independent review organization as set forth below under Optional Hearing. This is not a required step in the appeals process.

INDEPENDENT REVIEW ORGANIZATION

What the Enrollee must do: Request a review by an independent review organization. An independent review organization is not legally affiliated or controlled by GHO. Once a decision is made through an independent review organization, the decision is final and cannot be appealed through GHO.

A request for a review by an independent review organization must be made within 180 days after the date of the Step 1 decision notice, or within 180 days after the date of a GHO appeals committee decision notice.

REQUEST FOR AN OPTIONAL HEARING

Enrollees electing the appeals committee maintain their right to appeal further to an independent review organization as set forth above.

Review by the appeals committee is not available if the appeal request is for an experimental or investigational exclusion or limitation.

A request for a hearing by the appeals committee must be made within thirty (30) days after the date of the Step 1 decision notice.

What GHO must do: The appeals committee hearing is an informal process. The hearing will be conducted within thirty (30) working days of the Enrollee's request and notification of the appeal committee's decision will be mailed to the Enrollee within five (5) working days of the hearing.

EXPEDITED APPEAL PROCESS

There is an expedited appeals process in place for cases which meet criteria or where the Enrollee's provider believes that the standard thirty (30) day appeal review process will seriously jeopardize the Enrollee's life, health or ability to regain maximum function or subject the Enrollee to severe pain that cannot be managed adequately without the requested care or treatment. The Enrollee can request an expedited appeal in writing to the above address, or by calling GHO's Member Appeals Department toll free 866-458-5479. The Enrollee's request for an expedited appeal will be processed and a decision issued no later than seventy-two (72) hours after receipt. For expedited appeals, the Enrollee has the right to request an appeal through GHO's Member Appeal Department and a review by an independent review organization concurrently.

ELIGIBILITY

Eligibility for Public Employees Benefits Board (PEBB) benefits is based on rules in Washington Administrative Code (WAC) chapters 182-08 and 182-12. These rules can be found at **www.pebb.hca.wa.gov** in the *PEBB Rules and Policies* section of the website.

ELIGIBLE EMPLOYEES

Employees (referred to in the Eligibility and Enrollment sections as “employees,” “subscribers” or “enrollees”) are eligible for enrollment in Public Employees Benefits Board (PEBB) medical plans as described in WAC 182-12-114.

ELIGIBLE DEPENDENTS

To enroll in a health plan a dependent must be eligible under WAC 182-12-260 and the subscriber must follow the enrollment requirements outlined in WAC 182-12-262.

The PEBB Program verifies the eligibility of all dependents and reserves the right to request documents from subscribers that prove a dependent's eligibility. The PEBB Program will remove a subscriber's dependents from health plan enrollment if the PEBB Program is unable to verify a dependent's eligibility. The PEBB Program will not enroll or reenroll dependents into a health plan if the PEBB Program is unable to verify a dependent’s eligibility.

The following are eligible as dependents under the PEBB eligibility rules:

(1) Lawful spouse.

(2) Effective January 1, 2010, Washington State-registered domestic partners, as defined in RCW 26.60.020(1).

(3) Children. Children are defined as the subscriber's biological children, stepchildren, legally adopted children, children for whom the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of the child, children of the subscriber's Washington State-registered domestic partner, or children specified in a court order or divorce decree.

In addition, children include extended dependents in the legal custody or legal guardianship of the subscriber, the subscriber's spouse, or subscriber's Washington State-registered domestic partner. The legal responsibility is demonstrated by a valid court order and the child's official residence with the custodian or guardian. "Children" does not include foster children for whom support payments are made to the subscriber through the state Department of Social and Health Services foster care program.

Eligible children include:

(a) Children up to age 26.

(b) Effective January 1, 2011, children of any age with a disability, mental illness, or intellectual or other developmental disabilities who are incapable of self-support, provided such condition occurs before age 26. Also note:

- The subscriber must provide evidence of the disability and evidence that the condition occurred before age 26.
- The subscriber must notify the PEBB Program in writing no later than 60 days after the date that a child age 26 or older no longer qualifies under this eligibility. For example, children with a disability who become self-supporting are not eligible as of the last day of the month in which they become capable of self-support.
- Children age 26 and older who become capable of self-support do not regain eligibility under these criteria if they later become incapable of self-support.
- The PEBB Program will certify the eligibility of children with disabilities periodically.

(4) Parents.

a. Parents covered under a PEBB medical plan before July 1, 1990, may continue enrollment on a self-pay basis as long as all of the following are met:
    - The parent maintains continuous enrollment in a PEBB medical plan;
    - The parent qualifies under the Internal Revenue Code as a dependent of the subscriber;
    - The subscriber continues enrollment in PEBB insurance coverage; and
    - The parent is not covered by any other group medical plan.

b. Parents eligible under this subsection may be enrolled with a different medical plan than that selected by the subscriber. Parents may not enroll additional dependents to their insurance coverage.

ENROLLMENT

PEBB enrollment rules are described in chapters 182-08 and 182-12 WAC. These rules can be found at **www.pebb.hca.wa.gov** in the *PEBB Rules and Policies* section of the website.

An employee or dependent is eligible to enroll in only one PEBB medical plan even if eligibility criteria are met under two or more subscribers. For example, a dependent child who is eligible for enrollment under two or more parents working for employers that participate in PEBB coverage may be enrolled as a dependent under one parent, but not more than one.

Employees may waive enrollment in a PEBB medical plan if they are enrolled in other comprehensive group medical coverage. If an employee waives enrollment in a PEBB medical plan, the employee cannot enroll eligible dependents.

HOW TO ENROLL

Employees must submit an *Employee Enrollment/Change* form to their employing agency no later than 31 days after the date the employee becomes eligible for PEBB benefits. If the employee does not meet this requirement, the employee will be enrolled in the Uniform Medical Plan Classic, and any eligible dependents cannot be enrolled until the next open enrollment.

If an employee wants to enroll his or her eligible dependent(s) when the employee becomes eligible to enroll in PEBB benefits, the employee must include the dependent's enrollment information on the appropriate forms within the relevant time limits described in WAC 182-08-197. In addition, the employee must provide the required document(s) as evidence of the dependent's eligibility.

An employee or his or her dependents may enroll during the annual open enrollment (see Annual Open Enrollment section) or during a special open enrollment (see Special Open Enrollment section), if the change in enrollment corresponds to the event that creates the special open enrollment for either the employee or the employee's dependent or both. The employee must provide evidence of the event that created the special open enrollment.

WHEN MEDICAL ENROLLMENT BEGINS

For an employee and the employee's eligible dependent, enrolled when the employee is newly eligible, medical plan enrollment will begin when the employee's insurance coverage begins as described in WAC 182-12-114.

For an employee or an employee's eligible dependent enrolled during the annual open enrollment, medical coverage will begin on January 1 of the following year.

For an employee or an employee's eligible dependent enrolled during a special open enrollment, medical coverage will begin the first day of the month following the later of the event date or the date the form is received.

Exceptions:

1. If adding a child due to birth or adoption (or subscriber assuming a legal obligation for total or partial support in anticipation of adoption), medical coverage will begin on the day the child is born or adopted.
2. If adding a child who becomes eligible as an extended dependent through legal custody or legal guardianship, or a child who becomes eligible as a dependent with a disability, medical coverage will begin on the first day of the month following eligibility certification.

REMOVING DEPENDENTS

Employees are required to notify their employing agency to remove dependents no later than 60 days from the date a dependent no longer meets the eligibility criteria described under Eligible Dependents (WAC 182-12-250 or WAC 182-12-260). Consequences for not submitting notice within 60 days may include, but are not limited to:

- The dependent may lose eligibility to continue health plan coverage under one of the continuation coverage options described in WAC 182-12-270;
- The subscriber may be billed for claims paid by the health plan for services that were rendered after the dependent lost eligibility;
- The subscriber may not be able to recover subscriber-paid insurance premiums for dependents that lost their eligibility; and
- The subscriber may be responsible for premiums paid by the state for the dependent's health plan coverage after the dependent lost eligibility.

ANNUAL OPEN ENROLLMENT

Employees may make changes to their enrollment during any PEBB annual open enrollment period as long as they submit the change within required time limits. During the annual open enrollment employees may make a change to their enrollment as follows:

- Enroll in or waive his or her enrollment in a medical plan;
- Enroll or remove eligible dependents; or
- Change medical plan choice.

The employee must submit the appropriate change form to their employing agency no later than the end of the annual open enrollment (usually November 30). The enrollment change will become effective January 1 of the following year.

SPECIAL OPEN ENROLLMENT

Employees may change their enrollment outside of the annual open enrollment if a special open enrollment event occurs. However, the Internal Revenue Code (IRC) must allow the change and it must correspond to the event that creates the special open enrollment for either the employee or the employee's dependent (or both).

To make an enrollment change, the employee must submit the appropriate form(s) to his or her employing agency no later than 60 days after the event that created the special open enrollment. In addition to the appropriate forms, the PEBB Program or employing agency may require the employee to prove eligibility or provide evidence of the event that created the special open enrollment.

Exception: If an employee wants to enroll a newborn or child whom the subscriber has adopted (or has assumed a legal obligation for total or partial support in anticipation of adoption), the employee should notify their employer by submitting an enrollment form as soon as possible to ensure timely payment of claims. If adding the child increases the premium, the subscriber **must** submit the appropriate enrollment form no later than 12 months after the date of the birth, adoption, or the date the legal obligation is assumed for total or partial support in anticipation of adoption. Employees should contact their payroll, personnel or insurance office to obtain the appropriate forms.

NOTE: If an enrollee's provider or health care facility discontinues participation with GHO, the enrollee may not change medical plans until the next open enrollment period, unless the PEBB Appeals Manager determines that a continuity of care issue exists. GHO cannot guarantee that any one physician, hospital, or other provider will be available or remain under contract with us. Also, if an employee transfers from one employing agency to another during the year, the enrollee cannot change medical plans, except as outlined above or in WAC 182-08-197.

An eligible qualifying event must occur to create a special open enrollment that allows an employee to:

- Enroll in or change his or her health plan,
- Waive his or her health plan enrollment, or
- Enroll or remove eligible dependents

When can an employee enroll in or change his or her health plan?
Any one of the following events may create a special open enrollment:

1. Employee acquires a new dependent due to:
    a. Marriage or registering a domestic partnership with Washington's Secretary of State,
    b. Birth, adoption or when the subscriber assumes a legal obligation for total or partial support in anticipation of adoption,
    c. A child becomes eligible as an extended dependent through legal custody or legal guardianship, or
    d. A child becomes eligible as a dependent with a disability.

2. Employee or an employee's dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA);
3. Employee or an employee's dependent has a change in employment status that affects the employee's or the employee's dependent's eligibility for the employer contribution toward group health coverage;
4. Employee or an employee's dependent has a change in residence that affects health plan availability. If the employee moves and the employee's current health plan is not available in the new location the employee must select a new health plan. If the employee does not select a new health

plan within the required time limits the PEBB Program will enroll the employee in a health plan as described in WAC 182-08-196;

5. Employee receives a court order or medical support order requiring the employee, the employee's spouse, or employee's Washington State-registered domestic partner to provide insurance coverage for an eligible dependent (a former spouse or former qualified or registered domestic partner is not an eligible dependent);
6. Employee or an employee's dependent becomes eligible for state premium assistance through Medicaid or a state children's health insurance program (CHIP), or the employee or dependent loses eligibility for coverage under Medicaid or CHIP;
7. Employee or an employee's dependent becomes entitled to Medicare, enrolls in or disenrolls from a Medicare Part D plan. If the employee's current health plan becomes unavailable due to the employee's or an employee's dependent's entitlement to Medicare, the subscriber must select a new health plan as described in WAC 182-08-196;
8. Employee or an employee's dependent's current health plan becomes unavailable because the subscriber or enrolled dependent is no longer eligible for a health savings account (HSA). HCA may require evidence that the subscriber or subscriber's dependent is no longer eligible for an HSA;
9. Employee experiences a disruption that could function as a reduction in benefits for the employee or the employee's dependent(s) due to a specific condition or ongoing course of treatment. An employee may not change his or her health plan if the employee's or an enrolled employee's physician stops participation with the employee's health plan unless the PEBB Program determines that a continuity of care issue exists. The PEBB Program criteria used will include, but is not limited to, the following:
    a. Active cancer treatment; or
    b. Recent transplant (within the last 12 months); or
    c. Scheduled surgery within the next 60 days; or
    d. Major surgery within the previous 60 days; or
    e. Third trimester of pregnancy; or
    f. Language barrier.

    If the employee is having premiums taken from payroll on a pretax basis, a plan change will not be approved if it would conflict with provisions of the salary reduction plan authorized under RCW 41.05.300.

When can an employee waive his or her medical plan enrollment?

Any one of the following events may create a special open enrollment:

1. Employee acquires a new dependent due to:
    a. Marriage or registering a domestic partnership with Washington's Secretary of State,
    b. Birth, adoption or when the employee has assumed a legal obligation for total or partial support in anticipation of adoption,
    c. A child becoming eligible as an extended dependent through legal

custody or legal guardianship, or
d. A child becoming eligible as a dependent with a disability.

2. Employee or an employee's dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA);
3. Employee or an employee's dependent has a change in employment status that affects the employee's or employee's dependent's eligibility for the employer contribution toward group health coverage;
4. Employee receives a court order or medical support order requiring the employee, the employee's spouse, or employee's Washington State-registered domestic partner to provide insurance coverage for an eligible dependent (a former spouse or former qualified or registered domestic partner is not an eligible dependent);
5. Employee or an employee's eligible dependent becomes eligible for state premium assistance through Medicaid or a state children's health insurance program (CHIP), or the employee or an employee's dependent loses eligibility for coverage under Medicaid or CHIP.

When can an employee enroll or remove eligible dependents?
Any one of the following events may create a special open enrollment:

1. Employee acquires a new dependent due to:
   a. Marriage or registering a domestic partnership with Washington's Secretary of State,
   b. Birth, adoption or when an employee has assumed a legal obligation for total or partial support in anticipation of adoption,
   c. A child becoming eligible as an extended dependent through legal custody or legal guardianship, or
   d. A child becoming eligible as a dependent with a disability.

2. Employee or an employee's dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA);
3. Employee or an employee's dependent has a change in employment status that affects the employee's or employee's dependent's eligibility for the employer contribution toward group health coverage;
4. Employee receives a court order or medical support order requiring the employee, the employee's spouse, or employee's qualified or Washington State-registered domestic partner to provide insurance coverage for an eligible dependent (a former spouse or former qualified or registered domestic partner is not an eligible dependent);
5. Employee or an employee's dependent becomes eligible for state premium assistance through Medicaid or a state children's health insurance program (CHIP), or the employee or dependent loses eligibility for coverage under Medicaid or CHIP.

MEDICARE ENTITLEMENT

If an enrollee becomes entitled to Medicare, he or she should contact the nearest Social Security Administration Office to inquire about the advantages of immediate or deferred Medicare enrollment.

For employees and their enrolled spouses age 65 and older, the PEBB medical plan will provide primary insurance coverage, and Medicare coverage will be secondary. However, employees age 65 and older may choose to reject his or her PEBB medical plan and choose Medicare as their primary insurer. If an employee does so, the employee cannot enroll in a PEBB medical plan. The employee can again enroll in a PEBB medical plan during a special open enrollment or annual open enrollment. However, the employee may remain enrolled in PEBB dental, life and long-term disability insurance coverage.

In most situations, employees and their spouses can elect to defer Medicare Part B enrollment, without penalty, up to the date the employee terminates employment or retires. If Medicare entitlement is due to disability, the enrollee must contact Medicare about deferral of premiums. Upon retirement, Medicare will become the primary insurance, and the PEBB medical plan becomes secondary.

Medicare guidelines direct that qualified/Washington State-registered domestic partners who are age 65 or older must have Medicare as their primary insurer.

WHEN MEDICAL ENROLLMENT ENDS

Medical plan enrollment ends on the following dates:

1. At midnight on the last day of the month when any individual ceases to be eligible for
   PEBB insurance coverage.
2. On the date a plan terminates, if that should occur. Any person losing coverage will be given the opportunity to enroll in another PEBB medical plan.

Premium payments are not prorated if an enrollee dies or cancels his or her medical plan before the end of the month.

If an enrollee or newborn eligible for benefits under “Obstetric and Newborn Care” is confined in a hospital or skilled nursing facility for which benefits are provided when PEBB medical coverage ends and the enrollee is not immediately covered by other health plan coverage, employer contribution to insurance coverage will be extended until whichever of the following occurs first:

- the enrollee is discharged from the hospital or from a hospital to which the enrollee is directly transferred;

- the enrollee is discharged from a skilled nursing facility when directly transferred from a hospital when the skilled nursing facility confinement is in lieu of hospitalization;
- the enrollee is discharged from the skilled nursing facility or from a skilled nursing facility to which the enrollee is directly transferred;
- the enrollee is covered by another health plan that will provide benefits for the services; or
- benefits are exhausted.

When medical plan enrollment ends, the enrollee may be eligible for continuation of coverage or conversion to other health plan coverage if application is made within the timelines explained in the following sections.

The enrollee is responsible for timely payment of premiums. **If the enrollee's insurance coverage is canceled due to lack of payment, the enrollee's eligibility to participate in PEBB benefits will end.**

If you need help getting the correct form for an enrollment or benefit change please call PEBB Customer Service at 1-800-200-1004 or download the form at **www.pebb.hca.wa.gov**.

OPTIONS FOR CONTINUING PEBB BENEFITS

Employees and their dependents covered by this health plan have options for continuing insurance coverage during temporary or permanent loss of eligibility. There are four possible continuation coverage options for PEBB health plan enrollees:

1. COBRA
2. PEBB Extension of Coverage
3. Leave Without Pay (LWOP) Coverage
4. PEBB retiree insurance coverage

The first three options temporarily extend group insurance coverage in some cases when the subscriber or dependent's PEBB medical plan and dental plan coverage ends. COBRA continuation coverage is governed by eligibility and administrative requirements in federal law and regulation. PEBB Extension of Coverage is an alternative created for PEBB enrollees who are not eligible for COBRA. LWOP coverage is an alternative in specific situations.

The fourth option above is only available to individuals who meet eligibility and procedural requirements defined in WAC 182-12-171 or surviving dependents who meet eligibility requirements defined in WAC 182-12-250 or 182-12-265. These rules can be found at **www.pebb.hca.wa.gov** in the *PEBB Rules and Policies* section of the website.

All four options are administered by the PEBB Program. Refer to the *PEBB Continuation of Coverage Election Notice* booklet or the PEBB *Retiree Enrollment Guide* for specific details or call PEBB Customer Service at 1-800-200-1004.

Employees also have the right of conversion to individual medical insurance coverage when continuation of group medical insurance coverage is no longer possible. The employee's dependents also have options for continuing insurance coverage for themselves after losing eligibility.

FAMILY AND MEDICAL LEAVE ACT OF 1993

Employees on approved leave under the federal Family and Medical Leave Act (FMLA) may continue to receive up to 26 weeks of employer-paid medical, dental, basic life, and basic long-term disability insurance. The employee's employing agency is responsible for determining if the employee is eligible for leave and the duration of the leave under FMLA. The employee must continue to pay the employee premium contribution during this period to maintain eligibility. After that, insurance coverage may be continued as explained in the section titled "Options for Continuing PEBB Benefits."

PAYMENT OF PREMIUM DURING A LABOR DISPUTE

Any employee or dependent whose monthly premiums are paid in full or in part by the employer may pay premiums directly to GHO or the HCA if the employee's compensation is suspended or canceled directly or indirectly as a result of a strike, lockout, or any other labor dispute for a period not to exceed six months.

While the employee's compensation is suspended or canceled, the employee shall be notified immediately by the HCA by mail addressed to the last address of record with the HCA, that the employee may pay premiums as they become due as provided in this section.

CONVERSION OF COVERAGE

Enrollees have the right to switch from PEBB group medical coverage to an individual conversion plan offered by GHO when they are no longer able to continue the PEBB group medical plan, or are not eligible for Medicare or another group insurance coverage that provides benefits for hospital or medical care. Enrollees must apply for conversion coverage no later than 31 days after their group medical plan ends.

Evidence of insurability (proof of good health) is not required to obtain the conversion coverage. The rates, coverage and eligibility requirements of our conversion program differ from those of the enrollee's current group medical plan. Enrollment in a conversion program may limit the enrollee's ability to later

purchase an individual medical plan without health screening or a preexisting condition waiting period. To receive detailed information on conversion options under this medical plan, call GHO.

APPEALS OF DETERMINATIONS OF PEBB ELIGIBILITY

Any employee or employee's dependent may appeal a decision about PEBB eligibility. Guidance on filing an appeal can be found in chapter 182-16 WAC (which governs PEBB appeals), and at **www.pebb.hca.wa.gov**.

RELATIONSHIP TO LAW AND REGULATIONS

The language of this Certificate of Coverage (COC) is based on the rules that administer the Health Care Authority's PEBB Program in chapters 182-08, 182-12, 182-16 WAC. In the case of a conflict between the rules and the language describing eligibility and enrollment in this COC, the rules shall govern. This agreement between the HCA and the contracted vendor for benefits shall be interpreted, administered, and enforced according to the laws and regulations of the state of Washington, except as preempted by federal law.

ENROLLEES' RIGHTS AND RESPONSIBILITIES

As a GHO Enrollee, you are entitled to certain rights such as dignity, privacy and informed participation in your treatment. With those rights come certain responsibilities.

As an Enrollee, you have the right:

- To be treated with respect and dignity by all Group Health staff.
- To privacy and confidentiality regarding your health and your care.
- To information about your rights and responsibilities as a patient and consumer.
- To information about Group Health, our practitioners and providers, and how to use our services.
- To receive timely access to quality care and services.
- To information about the qualifications of the professionals caring for you.
- To participate in decisions regarding your health care.
- To give consent to, or refuse care, and be told the consequences of consent or refusal.
- To an honest discussion with your practitioner about all your treatment options, regardless of cost or benefit coverage, presented in a manner appropriate to your medical condition and ability to understand.
- To join in decisions to receive, or not receive, life-sustaining treatment including care at the end of life.
- To create and update advance directives and have your wishes honored.
- To choose a personal primary care physician affiliated with Group Health.
- To expect your personal physician to provide, arrange, and/or coordinate your care.
- To change your personal physician for any reason.
- To be educated about your role in reducing medical errors and the safe delivery of care.
- To voice opinions, concerns, positive comments, or complaints.
- To appeal a decision and receive a response within a reasonable amount of time.
- To suggest changes to consumer rights and responsibilities and related policies.
- To receive written information in prevalent non-English language (as defined by the State).
- To receive oral interpretation services free of charge for all non-English languages.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- To be free from all forms of abuse or harassment.
- To request and receive a copy of your medical records, and request amendment or correction to such documents, in accordance with applicable state and federal laws.

Your responsibilities as a Group Health Enrollee:

- To provide accurate information, to the extent possible, that Group Health requires to care for you. This includes your health history and your current condition. Group Health also needs your permission to obtain needed medical and personal information. This includes your name, address, phone number, marital status, dependents' status, and name of other insurance companies.

- To use practitioners and providers affiliated with Group Health for covered health care benefits and services, except where services are authorized or allowed by Group Health, or in the event of emergencies.
- To know and understand your coverage, to follow plan procedures, and to pay for the cost of care not covered in your contract.
- To understand your health needs and to develop with your personal physician mutually agreed upon goals about ways to stay healthy or to get well when you are sick.
- To understand and follow instructions for treatment, and to understand the consequences of following or not following instructions.
- To be active, informed and involved in your care, and to ask questions when you do not understand your care or what you are expected to do.
- To be considerate of other members, your health care team, and Group Health. This includes arriving on time for appointments, and notifying staff if you cannot make it on time or if you need to reschedule.

OTHER SERVICES
Non-PEBB benefits available to plan enrollees

The benefits on this page are not part of the PEBB contract or premium, and you cannot file a PEBB disputed claim about them. Fees you pay for these services do not count toward PEBB deductibles or catastrophic protection out-of-pocket maximum.

20% Vision Hardware Discount – Shop at convenient Group Health Eye Care locations.

- Get a 20% vision hardware discount on one or more pairs of prescription eyeglasses or sunglasses.
- Get one set of contact lenses per year.
- Fitting and evaluation fees are not discounted. Call Customer Service at 1-888-901-4636 or go online to www.gheyecare.org for more information.

Additional Services

Group Health Audiology/Hear Center – Get a full range of the latest hearing aid technology from the world's leading manufacturers, as well as other custom devices and accessories at the Group Health Medical Centers in Everett, Bellevue, Seattle, Tacoma, and Olympia. Go to www.ghc.org/provider/hearingServices for more information.

24 Hour Consulting Nurse Service – When you want care advice or need to know if you should get immediate medical attention, Group Health's Consulting Nurse Service can help 24 hours a day. For details like the numbers to call, go to www.ghc.org/provider/consultingnurse.jhtml

Online and Mobile Services

MyGroupHealth for Members – Our online services at www.ghc.org are available to all members. Access valuable health risk assessment tools, select doctors and read their profiles, see medical center locations and programs, and browse thousands of health care topics. Plus, you can refill pharmacy prescriptions, view or download your PEBB Brochure, and take the Health Profile to assess your health. For more information, visit www.ghc.org/pebb

Group Health Medical Centers
When you get care at a Group Health Medical Centers location, you can log on to www.ghc.org to do things like exchange secure messages with your health care team, check your online medical record, get your lab and test results, and request an appointment.

Symptom Checker – This interactive tool guides you through a series of questions that can help you identify potential explanations for your symptoms. Try it out at www.ghc.org/kbase/symptomChecker

Our new smartphone app – Now you can use your smartphone to access many of the features you can enjoy online at MyGroupHealth for Members. Find out all the things you can do at www.ghc.org/mobile

Wellness Programs

Health Profile and Lifestyle Coaching – Make positive lifestyle changes with support from Group Health. Learn more at www.ghc.org/momentum

Wellness Visits and Screening – Schedule immunizations and free, recommended tests for men's and women's health. For more information, visit www.ghc.org/healthAndWellness

Weight Management Programs – See our positive solutions for long term weight loss. Visit www.ghc.org/products/weight_management

Tobacco Cessation – Giving up tobacco products isn't easy, but Group Health offers resources that can help you stop. For more information, visit www.ghc.org/healthAndWellness/index.jhtml?item=/common/healthAndWellness/healthyLiving/lifestyle/tobacco.html

Fitness Network – Connect with other Group Health members and get into shape with fun activities and special events at www.grouphealthfitnessnetwork.com

Individual and Family Policies – Get a range of individual and family policies for those who do not qualify for coverage under PEBB programs. Learn more at www.ghc.org/health_plans

For more information about these and other benefits available to Group Health members, please call Group Health Customer Service at 1-888-901-4636 toll-free or go online to our website at www.ghc.org/pebb

1065GHO-2011-12W